

South African Medical Journal



S.-A. Tydskrif vir Geneeskunde

Organ of the Medical Association of South Africa

Blad van die Mediese Vereniging van Suid-Afrika

Incorporating the South African Medical Record and the
Medical Journal of South Africa

Waarby ingelyf is die South African Medical Record and the
Medical Journal of South Africa

Registered at the General Post Office as a Newspaper

By die posswere as nuusblad geregistreer

Cape Town, 4 December 1954
Weekly 2s. 6d.

Vol. 28 No. 49

Kaapstad, 4 Desember 1954
Weekliks 2s. 6d.

IN THIS ISSUE—IN HIERDIE UITGAWE

Editorials: Van die Redaksie

Improved Health in Cape Coloured
Die Verbetering in die Gesondheid van die Kaapse Kleurling

Original Articles: Oorspronklike Artikels

The Significance of Haemoptisis
The Management of Keloid in the South African Bantu
The Treatment of Diarrhoea in Young Children and Infants
Case Report: Severe Acute Barbiturate Poisoning in a Child
Successfully Treated with Amphetamine Sulphate and
Picrotoxin
The Story of the Royal College of Obstetricians and Gynaecolo-
gists 1929-54
Two International Conferences in Spain

Amendment of By-Laws of the Association The Highly Respectable Practish-on-er
Sixth Examination for Degree of M.B., B.Ch. University of the Witwatersrand
Association News: Verenigingsnuus: Meeting of S. Eastern Division of Cape Western Branch
Passing Events: In die Verbygaan
New Preparations and Appliances: Nuwe Preparate en Toestelle
Reviews of Books: Boekresensies Correspondence: Briewerubriek

Support Your Own Agency Department
Ondersteun u Eie Agentskap-Afdeling
Professional Appointments
Professionele Betrekkings

(P. xxviii)
(Bl. xxviii)
(Pp. xxviii-xxx)
(Bl. xxviii-xxx)

Motion sickness can be controlled



Supplied in
packet containers
of 10 x 25 mgm. tablets

Although in recent years great improvements have been made in the design and construction of modern transport, many hours of preventable discomfort may still have to be endured whilst the traveller becomes acclimatized to the disturbing motion.

Many of your patients, at some time or other, will need personal protection against motion sickness. Reports from many sources clearly show that 'Avomine' provides this protection without unpleasant side-effects.

'A V O M I N E'

trade mark

brand

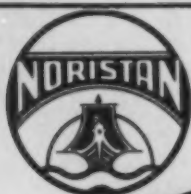
PROMETHAZINE 8-CHLOROTHEOPHYLLIMATE

An M&B Brand Medical Product

MA1355

DISTRIBUTORS: MAYBAKER (S.A.) (PTY.) LTD · P.O. BOX 1130 · PORT ELIZABETH

MANUFACTURED BY
MAY & BAKER LTD



New Heights in Sulphonamides!

SUPERIOR BACTERIOSTATIC EFFECT
HIGHEST SOLUBILITY
LOWEST TOXICITY
NO NOCTURNAL MEDICATION

ARISTAMID

TABLETS

0.5 gm. (7½ gr.)

6-Sulphanilamido-2:4-dimethyl pyrimidine

50, 250 and 750 tablets 9/8, 46/7 and 138/9
for the medical profession.

Under the formula of Nordmark-Werke GmbH. Hamburg-Germany

Manufactured in South Africa by
NORISTAN LABORATORIES (PTY.) LTD.-SILVERTON/PRETORIA.

DISPRIN

REGD.

*— Soluble, substantially neutral and palatable
aspirin tablets in stable tablet form*

Great difficulty has hitherto been encountered in providing soluble aspirin in tablet form which will remain stable under ordinary conditions of storage. This difficulty has now been overcome.

Disprin has all the valuable qualities of calcium aspirin—analgesic, antipyretic and anti-rheumatic. Since it is soluble, it is more rapidly absorbed and consequently more speedy in its clinical effect. Moreover, it is unlikely to irritate the gastric mucosa.

Disprin tablets readily dissolve in water to form a substantially neutral palatable solution of calcium aspirin.



Clinical samples and literature supplied on application.
Special hospital pack — prices on application.

Made by the manufacturers of "Dettol"

BECKITT AND COLMAN (AFRICA) LTD., P.O. BOX 1097, CAPE TOWN

M.2/MP

Acid Buttermilk Diet

of constant composition

The difficulty of preparing acid buttermilk is overcome by "Eledon". This half-cream dried milk product of constant composition has made it possible to prescribe a buttermilk diet whenever its use is indicated.

Under medical supervision "Eledon" has a specific use in the feeding of infants who do not thrive on the breast or the generally accepted milk formulas. Because of its relatively high and easily digested protein content, "Eledon" is ideal for premature infants as a substitute for, or an addition to, mother's milk.

"Eledon" is invaluable for infants and young children in diarrhoea; bacillary dysentery; malnutrition; cutaneous disorders including eczema; pylorospasm and in all cases where acidified milk is to be recommended.



Eledon

A NESTLÉ PRODUCT

Please Support Our Advertisers — Ondersteun Asseblief Ons Adverteerders

Rheumatoid Arthritis

"... to obtain maximal objective signs of improvement in articular function while receiving safe, suppressive doses of cortisone, it is essential to utilize a program of treatment that includes physical medicine"¹

The above quotation is taken from a recent report in the Journal of the American Medical Association giving comparative results of treatment of two groups of patients hospitalized with rheumatoid arthritis.

The physical medicine used in this study consisted of salicylates, proper diet, adequate rest and, in some instances, special articular supports.

Salicylate therapy... used with the control group of 34 patients... achieved a "marked or moderate" improvement of 80%. When Cortisone was administered simultaneously with salicylates to a group of 54 patients a slightly better result... only 5% better... was recorded.

When it is remembered that rheumatoid arthritis (the only arthritic disorder for which cortical hormones are indicated) accounts for an extremely small proportion of those afflicted with arthritic and rheumatic disorders, the proved effectiveness of salicylate therapy takes on added importance.

Confirmation of the value of salicylate therapy has been provided by clinical tests in Great Britain and Canada using the BERMIDE formula. This is of particular interest to South African physicians now making the "BERMIDE TEST"²

BERMIDE oral therapy may be freely prescribed for osteoarthritis, infectious and rheumatoid arthritis as well as for rheumatism, rheumatic fever and various forms of neuritis and sciatica. BERMIDE is well tolerated... safe for prolonged administration... relieves symptoms promptly... controls metabolic disturbances... restores normal physiological action... and BERMIDE is moderate in cost.

¹Gordon, M. Martin; Polley, Howard F.; Anderson, Thomas D.; *Physical Medicine Plus Cortisone for Rheumatoid Arthritis*, J.A.M.A., vol. 148, No. 7, February 16, 1952.

THE "BERMIDE TEST"

*The Pan Pharmaceuticals Company is offering supplies of BERMIDE—gratis—to physicians for them to make their own "BERMIDE TEST" with two patients suffering from Arthritic or Rheumatic disorders.

On receipt of a request from you, we will send you the large-size dispensing bottle of 500 BERMIDE tablets with complete recommendations for dosage. Additional supplies will be furnished as required.

BERMIDE is manufactured under licence and is the trademark of this product.

Bermide

THE PAN PHARMACEUTICALS COMPANY
P.O. BOX 447 — JOHANNESBURG

BER. 3

South African Medical Journal
Suid-Afrikaanse Tydskrif vir Geneeskunde
P.O. Box 643, Cape Town Posbus 643, Kaapstad

Cape Town, 4 December 1954
Weekly 2s. 6d.

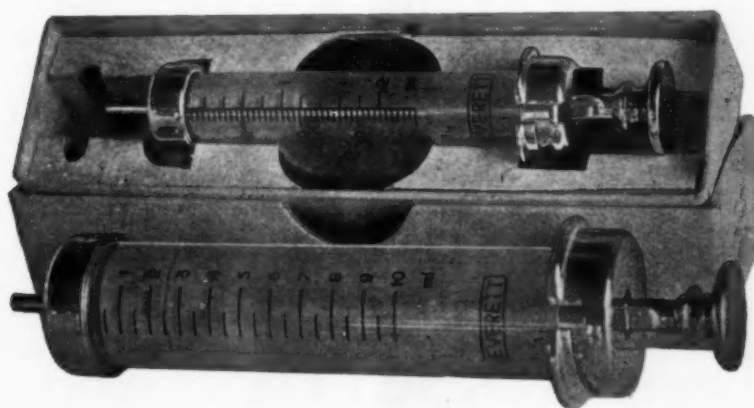
Vol. 28 No. 49

Kaapstad, 4 Desember 1954
Weekliks 2s. 6d.

CONTENTS — INHOUD

| | | | |
|--|------|---|------|
| The Significance of Haemoptisis: A Clinical Review based on 500 Cases. David Adler, F.R.C.S. (Edin.) and Denis Fuller, F.R.C.S. (Eng.) | 1029 | The Story of the Royal College of Obstetricians and Gynaecologists 1929-54. R. L. Impey, M.D., F.R.C.S. (Edin.), F.R.C.O.G. | 1047 |
| Amendments to By-Laws of the Association | 1032 | Two International Conferences in Spain. D. P. Marais, M.D. (Edin.), F.R.C.P. (Edin.) | 1042 |
| Editorials: Van die Redaksie | | The Highly Respectable Practish-on-er | 1044 |
| Improved Health in Cape Coloured | 1033 | Sixth Examination for Degree of M.B., B.Ch. University of the Witwatersrand | 1044 |
| Die Verbetering in die Gesondheid van die Kaapse Kleurling | 1033 | Association News: Verenigingsnuus (Meeting of South Eastern Division of Cape Western Branch) | 1045 |
| The Management of Keloid in the South African Bantu. J. C. Allen, M.Ch. and P. Keen, M.D. (Lausanne) | 1034 | Passing Events: In die Verbygaan | 1045 |
| The Treatment of Diarrhoea in Young Children and Infants. Frank Rousseau, M.B., Ch.B., D.C.H. | 1038 | New Preparations and Appliances: Nuwe Preparate en Toestelle | 1046 |
| Case Report: Severe Acute Barbiturate Poisoning in a Child Successfully Treated with Amphetamine Sulphate and Picrotoxin. B. Seftel, M.B., Ch.B. | 1040 | Reviews of Books: Boekresensies | 1046 |
| | | Correspondence: Briewerubriek | 1047 |

THE NEW SYRINGE
EVERETT'S LAMINEX RECORD TYPE



The Pistons, having the same co-efficient expansion as the barrels, ensure the barest minimum of breakages.

Clearest graduations.

Glass barrels made to withstand temperatures up to 200°C.

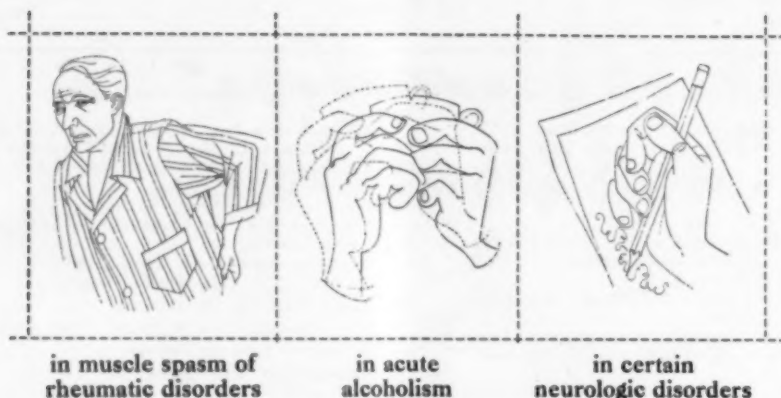
| | | | | | | |
|-------------|-------------|-------|--------|--------|---------|----------|
| 1c.c./20mm. | 2c.c./40mm. | 5c.c. | 10c.c. | 20c.c. | Central | Nozzles. |
| 6/6 | 7/6 | 10/6 | 12/6 | 14/6 | Side | " |
| — | — | 10/6 | 12/6 | 14/6 | | |

GURR SURGICAL INSTRUMENTS (Pty.) Ltd.

Harley Chambers - Kruis Street - P.O. Box 1562 - Johannesburg

Please Support Our Advertisers — Ondersteun Asseblief Ons Adverteerders

new uniform oral dosage



The new, uniform oral dose for adults is 1-3 grams. This may be repeated 3-5 times per day.

The first dose prescribed should be at the lower end of the recommended dosage range (*an occasional patient may complain of side effects when large doses are given at the start of Tolserol therapy*). Subsequent doses may be adjusted to the needs of the individual patient. Whenever possible, Tolserol should be given after meals. When Tolserol is given between meals, it is desirable that the patient first drink $\frac{1}{3}$ glass of milk or fruit juice.

Tolserol

Squibb Mephenesin

Tablets 0.5 Gm., Bottles of 100.

Further information and literature is available from

PROTEA PHARMACEUTICALS LTD.

7 Newton Street, Wemmer, Johannesburg.

P.O. Box 7793.

Telephone 33-2211.

also at Cape Town, Port Elizabeth, East London and Durban.

SQUIBB

"TOLSEROL" IS A TRADE MARK

MEDICAL **EVANS** SUPPLIES

HEPATEX

Fortified

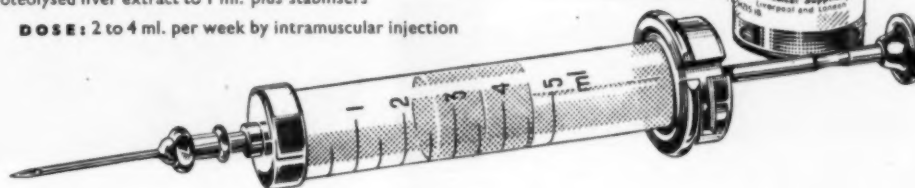
P6448

A new preparation for the treatment of all macrocytic anæmias with megaloblastic bone marrow, other than pernicious anæmia. In this improved preparation the folic acid content has been made fully stable by the addition of nicotinamide and para-amino-benzoic acid. (It is normally unstable at the pH required for Vitamin B₁₂ stability.)

COMPOSITION

Vitamin B₁₂ 15 microgrammes
Folic Acid 5 milligrammes
Crude proteolysed liver extract to 1 ml. plus stabilisers

DOSE: 2 to 4 ml. per week by intramuscular injection



HEPATEX FORTIFIED makes available to the patient all the important hamopoietic principles, which are derived from the proteolysis of whole liver and are present in the crude liver extract; and contains extra quantities of Vitamin B₁₂ and stabilised Folic Acid. HEPATEX FORTIFIED is therefore of especial value in the treatment of macrocytic anæmia in the tropics.

EVANS MEDICAL SUPPLIES

Sole Proprietors: E. S. L. & W. (S. AFRICA) (PTY) LTD. · P.O. BOX 6607 · 31-34 CORONATION BUILDINGS
23 SIMMONDS STREET · JOHANNESBURG

Excessive Perspiration

The hands of a girl of 17 with a history of hyperhidrosis of 9 years' duration. The sweating was a definite social handicap.



The same patient 45 minutes after taking 100 mg. of Banthine. She has been maintained on a schedule of 50 mg. three times daily. Illustrations courtesy of Keith S. Grimson, M.D.



Hyperhidrosis constitutes a serious mental as well as physical handicap. Its treatment is therefore highly important.

The control of this obstinate condition by Banthine is accomplished by the *true anticholinergic* action of the drug — an action which has made Banthine one of the outstanding drugs of recent years.

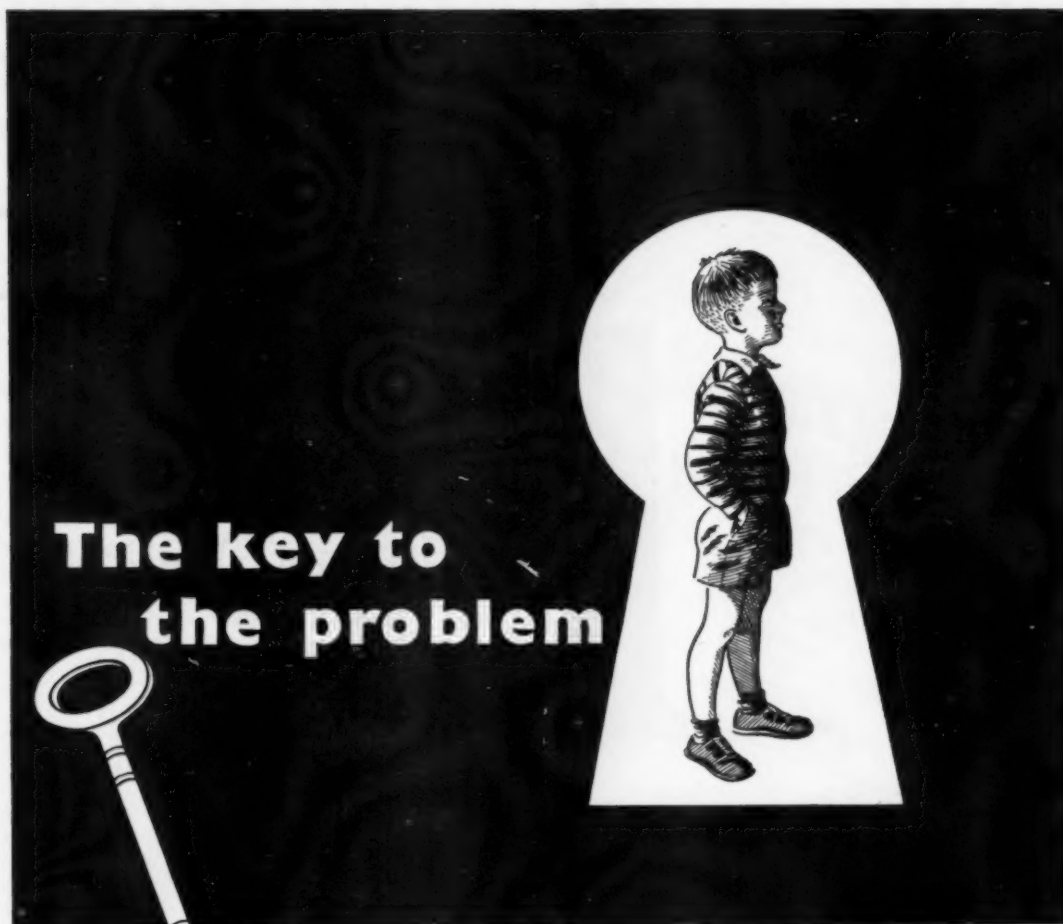
Pro-Banthine (Propantheline Bromide)

provides identical action to Banthine in the control of Hyperhidrosis.

One 15 mg. Pro-Banthine tablet has the same effect as a 50 mg. Banthine tablet.

KEATINGS PHARMACY LIMITED

P.O. Box 256, Johannesburg • P.O. Box 568, Cape Town • P.O. Box 2383, Durban • P.O. Box 789, Port Elizabeth.



The key to the problem

One of the most interesting uses of 'Benzedrine' Tablets is in the treatment of the child who is a problem to his parents, to his teachers, and often to his doctor. The abnormally aggressive, destructive, and unstable child often receives remarkable benefit from the administration of 'Benzedrine' Tablets. Outbursts of aggression become less frequent, ability to concentrate increases, and the improvement in behaviour

at home is matched by the improvement in performance at school.

'Benzedrine' Tablets are also of value to that other paediatric problem—enuresis. Given at bedtime, they lighten sleep so that afferent impulses from the bladder no longer fail to waken the patient.

Dosage: Children are remarkably tolerant of 'Benzedrine' Tablets. In behaviour disorders of children, 1 to 4 tablets daily. In enuresis, $\frac{1}{2}$ to 5 tablets at bedtime.

'Benzedrine' tablets

Each tablet contains 5 mg.
amphetamine sulphate
Issued in containers of 50 tablets

M. & J. PHARMACEUTICALS (PTY.) LIMITED, DIESEL STREET, PORT ELIZABETH
(Associated with MENLEY & JAMES, LIMITED, LONDON)

STP83SA for Smith Kline & French International Co., owner of the trade mark 'Benzedrine'

*The perfect extra
for babies...*



NESTUM is a carefully prepared, pre-cooked mixture of Whole Wheat, Barley Flour, Oatmeal and Wheat Gluten, together with Malt extract solids, Sucrose, Yeast solids and Vitamins. When the time comes to supplement baby's milk diet with a cereal, NESTUM is the answer. Babies will enjoy this added variety to their diet, and mothers will be happy to watch their continued progress and healthy development.

NESTUM

EASILY PREPARED—just mix with milk

Another good Nestlé's product!

For any further information write to:

NESTLÉ (S.A.) (PTY.) LTD.,

61, VICTORIA EMBANKMENT, DURBAN.

Unlike Ordinary Starch—

AVEENO COLLOIDAL OATMEAL

provides all 4 essential factors . . .

in colloid bath therapy

• COLLOID PROTECTION

. . . excellent viscosity without boiling

• DEMULCENT QUALITY

. . . due to 24% oat protein

• EMOLLIENT RELIEF

. . . due to 9% oat oil

• CLEANSING ACTION

. . . due to dirt-adsorbent quality.

Medical Price: 9/7 for 18-oz. packet

30/- for 4-lb. packet

Send for professional samples and literature

Available from your Chemist or Wholesaler.

Sole Distributors for South Africa:

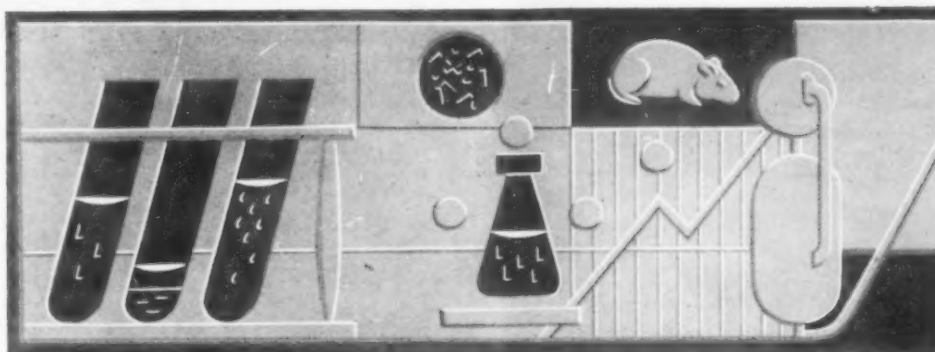
B. OWEN JONES, LTD

P.O. Box 8127 P.O. Box 36 P.O. Box 434 P.O. Box 679

Johannesburg Boksburg Cape Town East London

AVEENO COLLOIDAL OATMEAL

. . . for bland, soothing skin therapy.



HYDROCORTISONE

MADE IN ENGLAND

CORTISONE

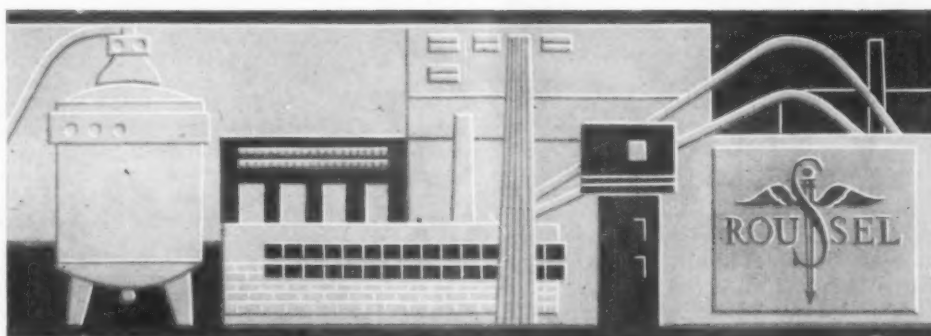


HYDROCORTISONE ACETATE

Local injection, 25 mg. per cc. ; 5 cc. vials
Skin ointment, 1% & 2.5% ; 5 G tubes
Eye drops, 1% suspension ; 3 cc. dropper bottles

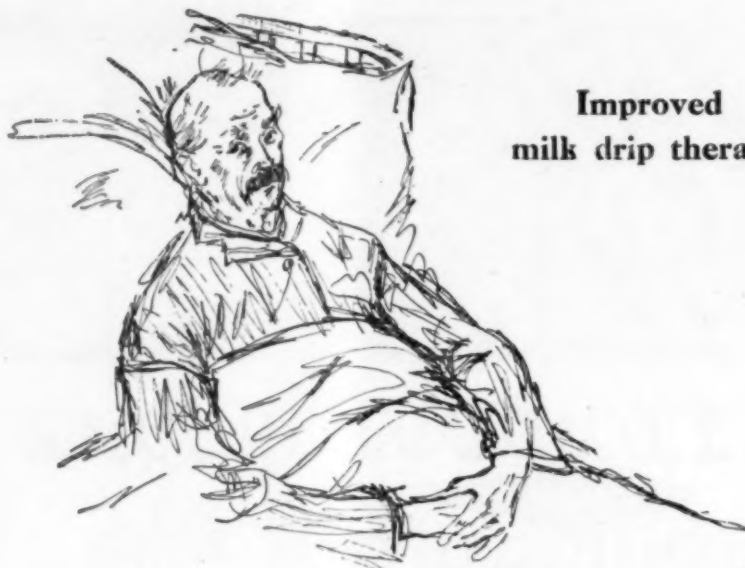
CORTISONE ACETATE

Injection, 25 mg. per cc. ; 10 cc. vials
Tablets, 5 mg. & 25 mg. ; Bottles of 20
Eye ointment, 1% ; 3 G tubes
Eye drops, 1% suspension ; 3 cc. dropper bottles



ROUSSEL LABORATORIES LTD., LONDON, N.W.10, ENGLAND

Sole Distributors for South Africa: FASSETT & JOHNSON LTD., 72-80 Smith Street, DURBAN (Telephone: 2-9521)
Sole Distributors for Southern Rhodesia: FASSETT & JOHNSON LTD., Goldfields Building, Main Street, BULAWAYO (Bulawayo 3345)



Improved milk drip therapy

Whenever *whole protein* cannot be ingested, digested, absorbed or utilised, Casydrol (Oral)—predigested protein—may well speed recovery and hence discharge from hospital.

Casydrol (Oral) is half amino-acids and polypeptides and half lactose—the lactose helps to meet the caloric needs of the patient and spares the protein for tissue regeneration. Casydrol (Oral) is ideally suitable for administration by intragastric drip and is an advance on milk drip therapy.

Casydrol

ORAL

A product of

Benger Laboratories

Literature is available on request.

BRITISH CHEMICALS & BIOLOGICALS (S.A.) (PTY.) LTD

259 COMMISSIONER STREET • JOHANNESBURG

South African Medical Journal

Suid-Afrikaanse Tydskrif vir Geneeskunde

P.O. Box 643, Cape Town

Posbus 643, Kaapstad

Cape Town, 4 December 1954
Weekly 2s. 6d.

Vol. 28 No. 49

Kaapstad, 4 Desember 1954
Weekliks 2s. 6d.

THE SIGNIFICANCE OF HAEMOPTYSIS

A CLINICAL REVIEW BASED ON 500 CASES

DAVID ADLER, F.R.C.S.(EDIN.)

and

DENIS FULLER, F.R.C.S.(ENG.)

Thoracic Surgeons, Johannesburg

There can be few more frightening symptoms than the appearance of blood in the sputum. Perhaps it is to allay this fear that the patient is reassured all along the line and told not to worry. The family practitioner with little to help him but the history and clinical examination, and often woefully deficient in the diagnosis of chest pathology, tells the patient that he has 'strained a vessel in the lung' or is 'bleeding from a varicose vein in the back of the throat'; the physician, in the presence of an indefinite radiological report and sputum specimens repeatedly negative for tubercle, feels he can safely reassure the patient that he is not suffering from tuberculosis; and the radiologist, where the radiological diagnosis is uncertain, recommends further X-ray examination at the end of a week or a month, instead of leaving it to the clinician to decide what further steps should be taken to investigate the case.

Experience has taught us that this *laissez faire* attitude has no place in the assessment of haemoptysis. Because this symptom is usually indicative of pathology we feel it might be of value to record our findings in 500 cases of haemoptysis, with a view to stimulating our colleagues into a renewed awareness of the seriousness of this sign.

The series comprises 500 consecutive cases seen in consultant thoracic surgical practice in Johannesburg over the past 7 years. These cases either suffered haemoptysis as their presenting symptom or had complained of blood-stained sputum before or during the course of their illness. The series could have been trebled by adding to it:

1. Cases seen at the General Hospital and the Children's Hospital, Johannesburg: unfortunately clerking facilities are inadequate and to add only such cases as we can trace would be misleading.

2. Cases seen and treated at Springkell (Tuberculosis) Sanatorium under the direction of Dr. M. A. Pringle: this would have weighed the cases disproportionately in favour of tuberculosis and would not have been representative, since much of the material is derived from the mines.

3. Cases following trauma: the number of these is small, since most assault or accident cases are admitted directly to the hospital.

We feel, however, that a survey of our cases seen in private practice will reflect accurately what the practitioner and physician should encounter, except for acute infections and pulmonary emboli. Cases of haemoptysis from mitral stenosis, now increasingly a surgical problem, were not referred to us in the earlier years.

PATHOLOGICAL SIGNIFICANCE OF HAEMOPTYSIS

In our experience the spitting of blood is almost invariably a warning of profound underlying lung pathology, often (as in carcinoma) menacing life, frequently (as in tuberculosis) invalidating the patient and threatening others, and usually (as in suppurative bronchiectasis) leading to chronic invalidism or bouts of ill-health. In other cases, e.g. mitral stenosis, haemoptysis indicates a profound disturbance in the haemodynamics of the pulmonary circulation, an imbalance which can now be readily and safely corrected.

A classification based on sound teaching principles, e.g. congenital, traumatic, inflammatory, neoplastic and cystic, is useful from the academic point of view; but instead we tabulate the cause of haemoptysis as determined in our cases in order of their frequency:

CAUSES OF HAEMOPTYSIS IN 500 CASES

| | | | |
|------------------------|-----|-------------------------------|---|
| Bronchiectasis | | Suppurative pneumonia | 7 |
| Suppurative | 88 | Bronchial adenoma | 6 |
| Dry haemorrhagic | 37 | Emphysematous cysts | 6 |
| Post-tuberculous | 14 | Congenital cysts | 5 |
| Carcinoma | | Tuberculous broncho-stenosis | 5 |
| Bronchogenic | 104 | Hypertension | 4 |
| Secondary | 8 | Fungi | 3 |
| Pulmonary tuberculosis | | Hydatids | 3 |
| Mitral stenosis | 47 | Amoebic abscess of liver | 2 |
| Chronic bronchitis | 39 | Inhaled foreign bodies | 2 |
| Lung abscess | 18 | Malignant mediastinal tumours | 2 |
| Pulmonary emboli | 17 | Coarctation of the aorta | 1 |
| Undiagnosed | 15 | Pulmonic stenosis | 1 |
| Chemical bronchitis | 8 | | |
| Post-operative | 7 | | |
| Trauma | 7 | | |

From this table it will be seen that 342 cases, i.e. 68% of all referred cases of haemoptysis, were due to bronchogenic carcinoma, bronchiectasis, pulmonary tuberculosis and mitral stenosis. On a purely statistical basis it is apparent that the patient suffering from haemoptysis is more than likely to be suffering from some disorder requiring full investigation and surgical intervention. It is not intended to discuss the diseases here; we wish merely to indicate the dangers of haemoptysis based on the following facts:

(a) *Sex.* Haemoptysis is more common amongst males. In this series 328 cases (66%) were males and 178 cases (34%) females. This male preponderance persists even when bronchogenic carcinoma is excluded. Only mitral stenosis and bronchial adenoma as causes of haemoptysis are commoner in women.

(b) *Age.* Haemoptysis occurs at all ages. The youngest patient seen was aged 20 months, and here haemoptysis was due to lung infiltration from a lymphosarcoma of the mediastinum. The oldest was 79 years of age, with a bronchogenic carcinoma. Haemoptysis appears to be commoner in the younger age group in women, 66% occurring below the age of 40 years; in males, however, 61% of cases of haemoptysis occurred over the age of 40.

(c) *Severity.* Apart from aneurysm of the aorta, the severity of haemoptysis appears to bear little relation to the underlying pathology. Daily blood-staining in a person over 40 years without pain is pathognomonic of carcinoma of the bronchus. Severe haemoptysis repeated after long free intervals usually indicates dry haemorrhagic bronchiectasis or, in females, bronchial adenoma. Sudden haemoptysis with severe pleuritic pain is mostly due to pulmonary infarction; small haemoptyses occurring in so-called 'bronchitis' in young females with dyspnoea is usually due to mitral stenosis. Blood-stained sputum with pus is most often due to suppurative bronchiectasis and, rarely today, in European practice at least, to lung abscess. Blood-staining, though often seen, is not common in tuberculosis and, as in all conditions, it can vary from a streak to a severe haemorrhage. Even a major injury such as a closed complete traumatic rupture of the bronchus has been seen with only the slightest trace of blood-stained sputum. It is

the presence of blood, and not the amount, that should be the signal for investigation.

(d) *Time Interval.* In 25% of our cases haemoptysis was either an early or a presenting symptom, and in these the severe were as numerous as the mild. In the remaining 75% haemoptysis was a late symptom and almost always slight. Thus severe haemoptysis is often an early symptom. It might be noted that of 130 cases of bronchogenic carcinoma 92 had experienced blood-staining; in 11% it was the initial symptom.

DIAGNOSIS

All cases must be investigated and a diagnosis must be made. This is a cardinal rule and is taught and accepted in all other spheres of medical practice—no one would think of reassuring a patient with haematuria, melaena or haematemesis, without establishing the cause.

Age Distribution. In European South Africans under the age of 35 years the commonest causes of haemoptysis in order of frequency, are (1) bronchiectasis, (2) pulmonary tuberculosis, (3) mitral stenosis, (4) chronic bronchitis, (5) pulmonary embolus, (6) lung abscess. Over the age of 35 the order of frequency is (1) bronchogenic carcinoma, (2) bronchiectasis, (3) pulmonary embolus, (4) pulmonary tuberculosis, (5) chronic bronchitis, (6) lung abscess.

Bronchiectasis. In clinical practice this is the most common cause of haemoptysis; it was responsible in 28% of our cases.

The sputum is often blood-stained in the periodic acute episodes which characterize the disease. In other cases the sputum is blood-stained at irregular intervals; in some haemoptysis is the only symptom of the underlying bronchial lesion—so-called dry haemorrhagic bronchiectasis. The diagnosis of bronchiectasis should not await the classical picture of foetid sputum and clubbing described in older text-books; it should be suspected in any chronic productive cough, even when there are no abnormal clinical signs, especially when mucopurulent sputum is induced by posturing the patient head down over the bed. Chronic antral infection with post-nasal drip and bronchial inhalation can simulate these cases very closely. Bronchography is essential not only for confirmation of the disease but to assess the operability.

Bronchogenic Carcinoma caused haemoptysis in 22% of this series. The appearance of blood in the sputum for the first time in a patient over the age of 35 years is highly suggestive of bronchogenic carcinoma. Repeated staining occurs only in this disease and in pulmonary hydatids. Over half of such cases will, on investigation, be found to be suffering from carcinoma. Although the haemoptysis may be the first symptom for which the patient consulted his doctor, the underlying lesion is most likely to be already in an advanced pathological state.

Pulmonary Tuberculosis. Haemoptysis due to tuberculosis accounted for 9% of this series. Although the blood-staining may be the symptom for which the practitioner is consulted, a careful history will usually reveal previous symptoms of general malaise, lassitude, anorexia, loss of weight, or cough and sputum. Even

careful clinical examination may be completely negative and a full radiological investigation is mandatory. Three negative sputum-tests should not suffice to lull the attending doctor into a false sense of security.

Mitral Stenosis. Haemoptysis occurs very commonly in this disease and 9% of our series were due to mitral stenosis. Usually the sputum is blood-stained only during an attack of pulmonary congestion, which is often misnamed 'bronchitis'. Occasionally the haemoptysis, severe and repeated, is the only subjective symptom of a tight mitral orifice. Usually, however, there is a history of exertional dyspnoea. In a recent series of 50 cases subjected to valvotomy and reviewed in this *Journal*,¹ 31 gave a history of haemoptysis.

Chronic Bronchitis. Although 8% of this series have been ascribed to bronchitis, this diagnosis is never made on clinical grounds only though it is often suspected. The history of a chronic cough, especially in some occupations, with winter exacerbations but no relation to posture is suggestive but not diagnostic. Full investigation is necessary to exclude other pathological conditions before a diagnosis of chronic bronchitis is accepted.

Pulmonary Embolus. This is often an unrecognized cause of haemoptysis, despite the associated pain and resultant effusion. In this series 3% of the cases were due to emboli. If there are signs of deep-vein thrombosis, the diagnosis is easy: in some of these cases the only sign is a variation of temperature in the calf (a skin thermometer is as useful as the conventional type in a thoracic surgical ward). It must be recalled that in many cases of confirmed pulmonary emboli no signs are found in the legs; and thrombo-embolism frequently occurs silently.

Lung Abscess. This condition used to be far commoner but with the universal use of antibiotics fewer cases are now seen in Europeans. In our series we have only 18 cases of lung abscess causing haemoptysis. The history of a recent dental extraction or minor upper respiratory operation followed initially by a dry cough with a nasty taste in the mouth should lead one to suspect a suppurative obstructive pneumonitis. When chest pain, fever, cough and purulent sputum occur a little later, the clinical diagnosis of a lung abscess is certain to be confirmed by radiology.

SUGGESTED PLAN OF INVESTIGATION

A full history must of course be taken and a careful clinical examination made of the patient. We regard as very important an examination of (a) the supra-clavicular fossae, where glands have been found in as many as 13% of our cases of carcinoma;² and (b) the legs, where calf and sole tenderness, alteration in temperature, or a possible Homan's sign, can confirm the diagnosis of deep-vein thrombosis. The investigation should then continue on the following lines:

1. Three specimens of sputum should be examined for tubercle. Negative results should not be accepted as conclusive, but should be followed by the next procedure, viz.
2. X-ray examination of the chest:
 - (a) *In Patients under the Age of 35 Years:*
 - (i) If the chest films are abnormal the condition is probably tuberculosis.
 - (ii) If the films are clear the condition is probably bronchiectasis. This can only be confirmed by bronchography, preferably by one of the newer contrast media such as Dionosil or by sulphalipiodol. This must be adequate not only to demonstrate the bronchiectatic segments of lung but also to delineate those parts that are normal.
 - (b) *In Patients over the Age of 35 Years:*
 - (i) If the films are clear the condition is probably bronchiectasis.
 - (ii) If there is a shadow, of whatever character, it is most likely to be a carcinoma and less likely to be tubercle.
3. Full investigation of any case whose treatment cannot be adequately and certainly directed on the above rough plan should be undertaken on the following lines:
 - (i) *Repeated sputum investigations*, depending on the history and X-ray appearance. If tubercle is suspected, repeated examinations of sputum, gastric lavages and laryngeal swabs should be employed. If carcinoma is suspected, fresh sputum should be put into rectified spirits and examined by a cytologist. If any infective condition is present full cultural and antibiotic sensitivity tests should be carried out.
 - (ii) *Radiological examination.* The value of good radiology cannot be over-emphasized. Postero-anterior, apical and lateral films should, of course, be a routine measure. No chest should ever be X-rayed without screening, to exclude obstructive emphysema. A barium swallow should never be omitted as much can be gained and excluded, e.g. pharyngeal pouches, cardiospasm, vascular rings, mitral stenosis, and especially the presence of mediastinal glands in malignancy. Adequate tomography is absolutely essential in the elucidation of all intra-thoracic lesions. Bronchography should not be used primarily in the presence of a shadow, but is mandatory when bronchiectasis is to be excluded. Angiocardiography is used to demonstrate the pulmonary tree in hilar growths and occasionally to distinguish the peripheral infiltrative lesions of carcinoma from pneumonitis.
 - (iii) *Bronchoscopy.* This procedure is essential in the diagnosis of cases of haemoptysis. MacHale³ discovered 4 tumours in 71 patients suffering from haemoptysis and with clear radiographs. Its greatest value is in confirming operability in bronchogenic carcinoma and in excluding tuberculous bronchitis when resection is contemplated for cases of tuberculosis and for bronchiectasis. In the presence of localized atelectasis or emphysema bronchoscopy should always be performed.
 - (iv) *Thoracoscopy* is sometimes of value in the presence of an associated effusion.
 - (v) *Thoracotomy* is often necessary to substantiate a suspected diagnosis of malignancy and to confirm operability. Frozen sections under such conditions are of the greatest value.

In about 3% of all cases of haemoptysis no definite pathological cause can be discovered despite full and adequate investigation. These cases should be watched and if there is any change either clinically or radiologically all the investigations should be repeated.

TREATMENT

The emergency treatment of haemoptysis depends on a diagnosis which can sometimes be established on a history of previous known chest trouble and only rarely on clinical examination. Perhaps the most important part of this investigation should be a thorough examination of the heart and legs as possible sources of emboli. Fortunately, since haemoptysis of itself is rarely fatal, morphine should be administered immediately and the patient and the relatives should be reassured.

If pulmonary infarction is diagnosed, anticoagulant therapy with the usual precautions should be commenced forthwith. If a suppurative condition is diagnosed sulphonomides and a penicillin preparation should be prescribed pending the results of a sputum culture.

Returning to the treatment of haemoptysis generally, provided deep-vein thrombosis is not present, it is probably as well to give ascorbic acid, vitamin K and any of the proprietary coagulants now marketed, more to satisfy the desire of the patient for active therapy than to conform to pharmacological principles. Rarely does haemoptysis from pulmonary tuberculosis endanger life; when it does an urgent therapeutic pneumothorax may have to be induced.

Once the haemoptysis has ceased, the patient must be fully investigated in accordance with the views expressed above and appropriate treatment advised.

CONCLUSION

Haemoptysis is a common clinical condition which in 97% of cases indicates pathology necessitating full investigation and adequate treatment.

REFERENCES

1. Adler, D. I. and Fuller, D. (1953): *S. Afr. Med. J.*, **27**, 1176.
2. *Idem* (1953): *Ibid.*, **27**, 841 and 874.
3. MacHale, S. J. (1953): *Thorax*, **8**, 164.

AMENDMENTS TO BY-LAWS OF THE ASSOCIATION

OFFICIAL ANNOUNCEMENT

Notice is hereby given that at the meeting of the Federal Council held in Pretoria on 30 October 1954, certain amendments were made to the By-Laws of the Association as follows:

1. By-Law 4 (a) was amended by the deletion of the words 'if elected' in the second line, so that it now reads: 'Every candidate for membership of the Association shall apply for election in writing, addressed to the Association, and stating his agreement to abide by the Regulations and By-laws, and the Rules of the Division and Branch to which he may at any time belong, and to pay his subscription for the current year.'
2. Present By-Law 5 was deleted and replaced by a new By-Law 5 reading: 'If legally qualified practitioners applying for membership are duly proposed and seconded by members of the Association, the Secretary shall forthwith declare them to be duly elected.'
3. By-Law 6 was amended by the addition of a sub-paragraph (c) reading: 'Members who have served the Association continuously for at least 45 years shall become Life Members.'
4. By-Law 23 was amended by the insertion of the words 'President or' before the word 'Chairman' in the first line, and the addition after the same word of the words 'a Vice-President or Vice-Chairman', so that it now reads: 'Each special Group shall appoint office-bearers consisting of a President or Chairman, a Vice-President or Vice-Chairman, an Honorary Secretary and Treasurer, and an Executive Committee of not less than three members to control the affairs of that Group. A list of such office-bearers, together with a complete list of the members of the Group, shall be furnished annually to the Medical Secretary within 30 days of the election of such office-bearers.'
5. By-Law 28 was amended by the addition of the sentence: 'A Group may elect to Honorary Membership of the Group persons of eminence who are not domiciled in the Union, provided that they are medical practitioners and members of their own national medical associations.'

By Order of the Council,

Medical House
Cape Town
16 November 1954

A. H. Tonkin
Secretary

AMPTELIKE AANKONDIGING

Kennis geskied hiermee dat op die vergadering van die Federale Raad wat op 30 Oktober 1954 in Pretoria gehou was, sekere wysigings in die Verordeninge van die Vereniging gemaak is, as volg:

1. Verordening 4 (a) is gewysig deur die weglating van die woorde 'indien gekies' in die derde reël, sodat dit nou lui: 'Elke kandidaat vir lidmaatskap van die Vereniging moet skriftelik aansoek doen om tot lid gekies te word en moet sy aansoek aan die Vereniging adresseer. Daarin moet hy verklaar of hy instem om hom neer te lê by die Reglemente en Verordeninge en by die Reëls van die afdeling en tak waaraan hy te eniger tyd mag behoort, en om sy subskripsie vir die lopende jaar te betaal.'
2. Die huidige Verordening 5 is geskrap en vervang deur 'n nuwe Verordening 5 wat as volg lui: 'Indien wettiglik gekwalifiseerde dokters wat om lidmaatskap aansoek doen behoorlik deur lede van die Vereniging voorgestel en geseondeer is sal die Sekretaris hulle onmiddellik as behoorlik verkose verklaar.'
3. Verordening 6 is gewysig deur die toevoeging van 'n bykomende paragraaf wat as volg lui: '(c) Lede wat die Vereniging vir minstens 45 jaar onafgebroke gedien het word lewenslange lede.'
4. Verordening 23 is gewysig deur die invoeging van die woorde 'president of' voor die woord 'voorsitter' in die eerste reël en van die woorde 'n onderpresident of ondervoorsitter' na dieselfde woord, sodat dit nou as volg lui: 'Elke spesiale groep moet ampsdraers aanstel bestaande uit 'n president of voorsitter, 'n onderpresident of ondervoorsitter, 'n ere-sekretaris en penningmeester, en 'n uitvoerende komitee van minstens drie lede om die sake van daardie groep te beheer. 'n Lys van sodanige ampsdraers, tesaam met 'n volledige lys van lede van die groep, moet jaarliks binne 30 dae na die verkiesing van sodanige ampsdraers aan die Mediese Sekretaris gestuur word.'
5. Verordening 28 is gewysig deur die toevoeging van die volgende sin: 'n Groep kan persone van aansien wat nie in die Unie woonagtig is nie tot ere-lede van die groep kies, mits hulle geneeshere en lede van hul eie nasionale mediese verenigings is.'

Op las van die Raad,

Mediese Huis
Kaapstad
16 November 1954

A. H. Tonkin
Sekretaris

5 **features**
that
put
Achromycin^{*}
Tetracycline Lederle
way ahead

- *more rapidly absorbed*
- *quicker diffusion in body tissues*
- *greater stability*
- *more prolonged blood levels*
- *fewer side-effects*

The medical profession has been quick to recognise that ACHROMYCIN represents a striking advance in antibiotic therapy. Not only is it a highly efficient drug, but it is also remarkably safe in use and simple to administer. In most cases, *oral* administration of ACHROMYCIN will secure high and prolonged levels in the blood and tissues that are all-important for therapeutic success.

ACHROMYCIN is effective against Gram-positive and Gram-negative cocci, Gram-negative bacilli, certain protozoa, viruses and rickettsia. In terms of hospital economics, ACHROMYCIN helps to shorten hospital stay, simplifying nursing care and making beds available more quickly.

Capsules: 50 mg.—vials of 25 and 100; 250 mg.—vials of 8 and 16, bottles of 100

SPERSOIDS† Dispersible Powder: Jars of 36 Gm. and 75 Gm. Each teaspoonful contains 50 mg. of Achromycin Tetracycline.

* Regd. Trade Mark † Trade Mark



LEDERLE LABORATORIES DIVISION

Cyanamid Products Ltd.

BUSH HOUSE • ALDWYCH • LONDON • W.C.2

Sole Agents in South Africa:

ALEX LIPWORTH LTD., 120 JEPPE STREET, P.O. BOX 4461, JOHANNESBURG

"DRAEGER" **IRON LUNG Model "E 52"**

Based on Latest Clinical Experiences.



- Physiologically Correct Manner of Functions.
- Comfort for the Patient.
- Easy Operation.
- Uninterrupted Respiration.
- First-class Technical Finish.

For Chamber and dome respiration. With alarm-device, lighting and heating, CO₂ measuring device, suction pump, special collars for shoulder-sealing, etc. Electrical and manual operation.

Hydromotor on request.

SAFETY & MEDICAL EQUIPMENT CO. (Pty) Ltd.

"Cambridge", cor. Sauer & Kerk Streets, Johannesburg.

Telephone 33-9625.

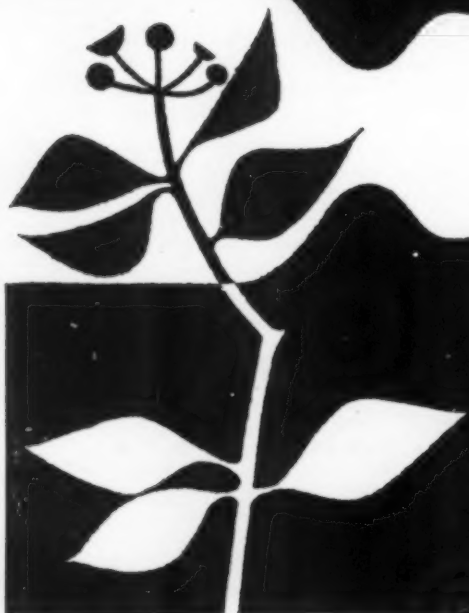
Cape Representatives:

MEDULTRA (Pty) Ltd.

Maynard Street, Wynberg, C.P.

Tel. 7-0445.

New! Serpasil in injectable form



Serpasil is the antihypertensive-principle of Rauwolfia, freed from all the ballast substances accompanying the crude root and extracts. It is now available to the doctor for the first time as an injection.

Indications: Initiation of treatment in hypertension, cases resistant to oral medication, acute hypertensive crises, toxæmias of pregnancy, etc.

CIBA Limited, Basle, Switzerland

Dosage: One ampoule b.i.d. intramuscularly, or slowly intravenously where this is thought essential. The patient should be kept in bed during parenteral treatment.

Packages: Ampoules of 1 cc. containing 1 mg of Serpasil. Boxes of 5 and 20.

Distributors for South Africa: Messrs. SANA Limited, P. O. Box 3951, Johannesburg

South African Medical Journal

Suid-Afrikaanse Tydskrif vir Geneeskunde

EDITORIAL

BETTER HEALTH IN THE CAPE COLOURED

Remarkable changes have taken place in the vital statistics of the European populations of most countries of the world; striking examples are the phenomenal decline in the infant mortality rate and the death rates from respiratory and diarrhoeal diseases. The White community of South Africa has shared fully in this improvement, but what is not so well known are the changes that in recent years have occurred in the death rates of non-European urban populations, as illustrated by the statistics published by the Medical Officer of Health of the City of Cape Town.

Ten years ago the general annual death rate of the non-Europeans of Cape Town exceeded 20 per 1,000, and was double that of the Europeans. During the 10 years the non-European death rate has steadily dropped, until in the last 2 years (1952-53 and 1953-54) it has fallen to 13.1 and 12.2 per 1,000, a decline of not far short of one-half.

When this death rate is calculated separately for the 3 non-European races we find that in the year 1953-54 it was 8.5 per 1,000 for 'Asiatics' (mostly Indians), 11.8 for the Cape Coloured and 15.8 for Natives (as compared with 9.37 for Europeans). Thus in this year the Cape Coloured death rate was only 26% greater than that of the Whites, and the Indian death rate was actually lower than the White.

Turning to Coloured infant mortality we also find an improvement. In 1953-54 the Cape Coloured infant mortality rate in Cape Town was 88 per 1,000 births, which, though the European rate for the same year was only 30, is less than the European rate was a little more than 30 years ago. This is all the more remarkable in the face of the high Cape Coloured birth rate, which in 1953-54 remained at the high figure of 38 per thousand population as compared with the European birth rate of 18. The Indian infant mortality rate in Cape Town for that year was 61, in the face of the enormous birth rate of 52.

Let us now consider certain diseases (already mentioned) that flourish in bad socio-economic conditions, viz. tuberculosis, respiratory diseases and diarrhoeal diseases. We find that in the 10 years from 1943-44 to 1953-54 the Cape Town non-European death rate from tuberculosis fell from 591 per 100,000 population to 177; bronchitis and pneumonia from 428 to 98; and diarrhoea and enteritis from 300 to 227 (a less striking com-

VAN DIE REDAKSIE

DIE VERBETERING IN DIE GESONDHEID VAN DIE KAAPSE KLEURLING

Die bevolkingstatistiek vir die blanke burgers van die meeste lande in die wêreld het merkwaardige veranderinge ondergaan; treffende voorbeelde is die verbasende daling in die kindersterftesyfer en die sterftesyfers vir asemhalings- en diaree-siektes. Die blanke gemeenskap van Suid-Afrika het ten volle in hierdie vooruitgang gedeel; minder bekend egter is die veranderinge wat die sterftesyfers vir die nie-blanke stedelike inwoners in onlangse jare ondergaan het. Statistiek wat deur die Mediese Gesondheidsbeampte van Kaapstad gepubliseer is, illustreer hierdie verandering.

Tien jaar gelede was die sterftesyfer vir die nie-blankes van Kaapstad hoër as 20 per 1,000 per jaar—twee maal so hoog soos die syfer vir die blankes. Gedurende die laaste 10 jaar het die nie-blanke sterftesyfer gestadiglik gedaal totdat dit 13.1 en 12.2 per 1,000 gedurende die pasafgelope 2 jare (1952-53 en 1953-54) bereik het—'n daling van bykans 50%.

As die sterftesyfer vir die jaar 1953-54 afsonderlik vir die 3 nie-blanke rasse bereken word, vind ons dat dit vir Asië (hoofsaaklik Indiërs) 8.5 per 1,000, vir kleurlinge 11.8, en vir naturelle 15.8 (teenoor 9.37 vir blankes) was. Die sterftesyfer vir kleurlinge was derhalwe vir hierdie jaar net 26% groter as vir blankes en die sterftesyfer vir Indiërs was laer as die sterftesyfer vir blankes.

Die kindersterftesyfer vir kleurlinge het ook verbeter. In 1953-54 was hierdie syfer vir Kaapstad, 88 per 1,000 geboortes in vergelyking met die kindersterftesyfer vir blankes van 30; dit is egter laer as wat die kindersterftesyfer vir blankes 30 jaar gelede was. Hierdie statistiek is des te meer opvallend as die hoë geboortesyfer vir kleurlinge in Kaapstad in aanmerking geneem word—in 1953-54 was hierdie syfer nog steeds so hoog soos 38 per 1,000 van die bevolking in vergelyking met 'n geboortesyfer van 18 vir blankes. Vir dieselfde tydperk was die kindersterftesyfer vir Indiërs in Kaapstad 61 en hul ontsaglike geboortesyfer was 52.

Ons neem nou sekere siektes (alreeds vermeld) in oënskou wat onder ongewenste socio-ekonomiese toestande tier, t.w. toring, asemhalings- en diaree-siektes. Ons vind dat oor 'n tydperk van 10 jaar, van 1943-44 tot 1953-54, die sterftesyfer vir toring onder nie-blankes in Kaapstad van 591 per 100,000 bevolking tot 177 gedaal het; bronchitis en longontsteking van 428 tot

parison). Although these figures still compare unfavourably with the corresponding European death rates (1953-54 per 100,000: tuberculosis 24, bronchitis and pneumonia 45 and diarrhoea and enteritis 5) they are an eloquent expression of a rapid improvement that has taken place in recent years in the health of the non-Europeans of Cape Town.

We know that amongst the factors that determine the public health, housing, nutrition and standard of living rank high. Owing to the shortage of houses a large proportion of the non-European people of Cape Town are living in excessive overcrowding, and many under bad housing conditions in other respects. The improvement in health can then hardly be explained in terms of housing; what is more likely is that it is largely due to improved nutrition and better social conditions generally, resulting from the increased wages that can now be earned. There are, however, other factors, and one that should not be overlooked is the medical and allied services which operate to make the modern advances in medicine available for the benefit of the people.

Whatever the cause, it appears that a rapid improvement is taking place in the health standards of the Cape Coloured people. Already they have reached a higher standard than that of the Europeans of last century, and provided the rapid socio-economic uplift continues which they have been enjoying in recent years, there is no reason why they should not aspire to health standards equal to those enjoyed by the White community at the present time.

98; diaree en dermontsteking van 300 tot 227 ('n minder opvallende vergelyking). Alhoewel hierdie syfers nog ongunstig vergelyk met die ooreenkomstige sterftesyfers vir blankes (1953-54 per 100,000: tering 24, bronchitis en longontsteking 45 en diaree en enteritis 5) gee dit nogtans 'n duidelike beeld van hoe die gesondheid van Kaapstad se nie-blanke inwoners gedurende onlangse jare met rasse skrede verbeter het.

Behuising, voeding en lewenspeil staan hoog aan die lys van faktore wat die openbare gesondheid beslis. As gevolg van die ernstige tekort aan huise lewe 'n groot persentasie van nie-blankes in Kaapstad onder toestande van die ernstigste oorbewoning en van baie ander is die behuisingomstandighede in ander opsigte swak. Die verbetering in gesondheid kan dus nie aan 'n verbetering in behuisingstoestande toegeskryf word nie. Meer waarskynlik is dit hoofsaaklik aan verbeterde dieet en maatskaplike omstandighede te danke wat op die huidige hoër lone volg. Ander faktore speel ook 'n rol en een van hul moet nie oor die hoof gesien word nie en wel die geneeskundige en verwante dienste wat die jongste ontwikkelings op die gebied van geneeskunde tot beskikking van die publiek stel.

Wat ookal die rede mag wees, die gesondheidspeil van die Kaapse Kleurling styg vinnig en het alreeds die peil oorskry wat die blankes in die afgelope eeu bereik het. As die snelle socio-ekonomiese verbetering wat hul gedurende onlangse jare geniet het, voortduur, is daar geen rede waarom hul nie dieselfde gesondheidspeil kan behaal nie wat die blanke gemeenskap tans bereik het.

THE MANAGEMENT OF KELOID IN THE SOUTH AFRICAN BANTU

J. C. ALLAN, M.Ch. (RAND)

and

P. KEEN, M.D. (LAUSANNE)

Department of Surgery, University of the Witwatersrand, Johannesburg

It is well known that keloid has a remarkable tendency to recur after excision; various methods, mainly involving the use of X-rays and radium, have been recommended by overseas workers to reduce the frequency of recurrence. However, as many of the suggestions made are not wholly applicable to the Bantu in South Africa, it was thought wise to record our experiences with the florid, long-standing keloids which usually present for treatment in our out-patient departments.

Levitt and Gillies (1942) maintained that the mild inflammatory reaction produced by X-rays was able to soften the developed keloid and prevent the onset of keloid in a susceptible individual. They emphasized (1) that the irradiation should be of erythema dosage, (2) that it should be applied to the skin surrounding a developed keloid rather than to the keloid itself, (3) that the lines of proposed incisions should be irradiated in a susceptible individual, and (4) that irradiation was preferably applied as a single pre-operative and post-

operative dose. They maintained also that certain types of developed keloid responded to irradiation alone and that with any very thick scar a period of up to 18 months or more must be allowed before the full result might be seen.

Pfahler and Keefer (1948) said that they had no proof of the value of pre-operative irradiation as a prophylactic measure in keloid formation, but that they had abundant proof of the value of immediate post-operative irradiation in the prevention of keloid. They recommended that very dense keloids should be destroyed to the level of the skin, or excised, and subsequent healing controlled by 2-80% erythema doses of X-rays at intervals of 2 weeks during the post-operative period. They stated also that hypertrophic scar was most sensitive to irradiation within the first month of hypertrophy.

Jacobsson (1948) stated that the results of treatment by the direct application of radium were so good that it should always be tried first, and that excision followed by irradiation was not a commendable procedure,

although such treatment might be necessary in radio-resistant keloids. In the majority of developed keloids treated with irradiation alone he observed total regression after about 2 years.

It is evident that all these authors are agreed that irradiation in one form or another is essential in the treatment of keloids, but they are by no means agreed as to when and where the irradiation should be applied.

ETIOLOGY

There is no doubt that certain individuals and races have a tendency to the development of keloid and hypertrophic scar, and the high incidence in certain bodily regions suggests an added regional susceptibility. That trauma alone is probably not the basic exciting factor in keloid production is indicated by the fact that all the attempts we have made to initiate new keloid formation by incisions, scarifications and puncture wounds in the vicinity of florid keloids, have resulted in failure. This finding indicates that an additional factor operates in keloid production.

The majority of keloids in the Bantu follow treatment by the witch-doctor. Simple scarification for blood-letting does not often result in keloid, but the rubbing-in of certain irritant powders predisposes to keloid formation. In one case several scarifications were treated alternately with different powders and only those treated with one of the powders became keloid. Infection, catgut skin sutures, and antiseptics, may also be regarded as irritative factors.

Keloids are rare in infancy and are very unusual under the age of 10 years. New keloid formation and post-operative hypertrophic scarring are uncommon after the age of 50 years. Vaccination keloid rarely occurs in Bantu children in urban areas, where early vaccination is the general rule, but vaccination in adulthood frequently produces keloid (Fig. 1). There is a tendency for



Fig. 1. Keloid following vaccination in an adult.

normal scars to become hypertrophic at puberty or during pregnancy. These features suggest that hormonal influences may affect the growth of keloids and that a susceptible person may have periods of increased susceptibility.

On the basis of the foregoing facts, we believe that 2 factors are necessary in the formation of keloids and hypertrophic scars, viz. (1) a keloid diathesis and (2) trauma with local irritation.

PATHOLOGY

The gross appearance of an advanced keloid is that of a projecting mass in the skin. The edges of the mass overhang the margin of attachment to the normal skin (Fig. 2 shoulders, and Fig. 3) and in circular keloids central umbilication is often present. The developed keloid is usually more pigmented than the surrounding skin. In general, the older the keloid the harder its consistency.



Fig. 2. Multiple keloids. Irradiation alone in 1944 and 1946 to several keloids to stop itching, gave some symptomatic relief. In 1950 the keloid on the right shoulder was excised and the area irradiated post-operatively with 2,000 r. The keloid on the left shoulder received 2,000 r pre-operatively and the epigastric keloid received 800 r pre-operatively and 1,600 r post-operatively. The scars on the shoulders became somewhat hypertrophic but caused no symptoms. The epigastric scar was supple and symptomless and in this case gave the best therapeutic result (see Fig. 2a).

The hypertrophic scar (as distinct from a keloid) is a raised fibrous ridge in the course of an incision which has injured the whole thickness of the skin. The edge of the ridge does not overhang the surrounding skin, and there are frequently projections into the surrounding tissues. Where there has been a sinus or a drainage tube in the wound the scar is thicker and denser than in the other parts. The hypertrophic scar is usually paler in colour than the surrounding skin. The scar becomes harder as its age increases. When recurrence occurs



Fig. 2 (a). Same case as Fig. 2 showing, after one year, the result of excision of the shoulder and epigastric keloids, with different therapeutic approaches.



Fig. 3. Section of a keloid showing the umbilication, overhanging edge, and sharp demarcation from the subcutaneous fat.

after removal of a true keloid the recurrence is of the nature of a hypertrophic scar and arises from the tissues surrounding the keloid.

Histologically the keloid consists of whorls of fibrous tissue confined to the superficial layer of the corium. The epithelium over the keloid is thicker than normal. In the hypertrophic scar, there are fibrous extensions into the surrounding skin and subcutaneous tissue.

On a basis of the preceding information, a keloid may

be defined as a *fibrous overgrowth in the skin resulting from trauma and irritation in a susceptible individual.*

THE POSITION IN SOUTH AFRICA

There are no statistics for the frequency of keloid in the Bantu in South Africa, but practice indicates that the condition is very common. In recent years the incidence of keloid appears to have increased; this is probably due to the fact that the attitude of the Bantu to keloid is gradually changing, and that sufferers are more desirous of having treatment in hospital, particularly from a cosmetic point of view. Ten years ago, the patient with keloid attended hospital only when infection or disability supervened.

As stated by Levitt and Gillies and by Jacobsson, it is best to prolong the period of treatment in the European to 18 months or 2 years. In the Bantu, however, some immediate visual effect of treatment is essential, and the psychological and economic conditions of the patient make prolonged treatment inadvisable. Minimal hospitalization with completion of treatment within 3 weeks should be the aim of the surgeon and radiotherapist.

The preceding points, and the fact that the end-results of treatment are difficult to assess in the Bantu, should be noted in formulating a practical policy of treatment, and in comparing our views with those of other workers.

TREATMENT

In the majority of cases that attend for treatment the keloids are of more than 1 year's duration and a considerable number are of more than 5 years. Most of the keloids seen are therefore radio-resistant; the experimental application of 5,000 r by radium in a well-established case caused only destruction of the epidermis of the keloid. In these cases, therefore, excision is an essential part of the treatment; irradiation is equally important to prevent recurrence and should be applied in a judicious manner.

In the preparation of the skin for excision thorough cleansing with soap and water followed by ether is sufficient. Antiseptics, especially those which contain heavy metals, should be avoided. The incision need not be further than 3 mm. from the edge of a keloid and should not pass outside the field of pre- or post-operative irradiation. Haemorrhage is controlled by a hot moist pack, by artery forceps held in position for a few minutes, or by the diathermy current; if ligatures are necessary, fine plain catgut is used. If retraction is required, tissue forceps should not be applied to the skin edges but to the subcutaneous tissues. Accurate skin approximation without tension must be secured. No antiseptic is applied to the wound after suture. Sutures are removed as soon as the wound-edges are securely adherent. This is found to be about the 12th day in cases in which pre-operative irradiation has been given and in certain cases as early as the 4th or 5th day when no irradiation has been given.

Irradiation is applied to the skin surrounding the keloid for a distance of at least 1 cm. from its edge and should include all areas where incisions are likely to be made. The keloid is excised between 8 and 14 days after cessation of pre-operative irradiation.

After numerous trials with dosages of irradiation varying from 500 r to 2,400 r applied before and after operation to the skin surrounding keloids, we have arrived at the conclusion that 800 r in a single dose, or in 2 equally-divided doses on successive days, is the optimum pre-operative dosage for keloid in the Bantu. Doses in excess of 800 r retard adherence of the wound edges and thus delay the removal of sutures, while doses less than 800 r appear to be of no benefit in the treatment.

The optimum post-operative irradiation dosage is 1,200 to 2,000 r in divided doses of 500 r daily, commencing on the 10th day after operation. As a rule a kilovoltage of 135 has been used and the rays filtered with 2 mm. aluminium.

Particular care is required when treating hypertrophic scars, because the fibrous reaction extends into the subcutaneous tissues. A hypertrophic scar of less than 6 months' duration regresses in about 8 weeks with 2,000 r. During the 6th to 12th month period the response to irradiation is slower, and if the scar is of longer than 12 months' duration, it should be treated as a keloid.

Frequently the extent of a keloid is such that skin-grafting is necessary to close the skin defect after excision. Pre-operative irradiation of 800 r does not retard the adherence and growth of the graft, and post-operative irradiation is confined to the margin of the graft. Donor areas are treated with 1,500 r in divided doses commencing on the 10th day after the operation.

A susceptible person who requires an operation for a condition other than keloid should receive prophylactic irradiation to the area where the incision is to be made. In emergency cases pre-operative irradiation cannot be given, and the treatment is confined to the convalescent stage or is applied as soon as there are signs of thickening of the operation scar.

It must be made clear that the views expressed in this paper are not based on a large series of cases accurately

followed up over a long period. In dealing with the Bantu 'follow ups' are notoriously difficult. However, a limited number of cases have been watched over periods varying from 4 to 10 years and the views expressed are based on these few cases and general impressions of various other cases (Fig. 4).

Recent reports on the beneficial effects of cortisone on keloids have tempted us to try its effects. In the few cases in which we have tried them, neither ACTH nor cortisone has had any visible or symptomatic effects on the established keloid seen in the Bantu. However, hydrocortone injected into the keloid, especially if hyaluronidase is added to the solution, has proved effective in a few cases in allaying itching, though no macroscopic changes were noted.

SUMMARY

1. The remarks in this paper apply only to the South African Bantu.
2. Keloid is common in the South African Bantu and the incidence of recurrence after 'adequate' excision is extremely high.
3. From a review of some of the factors operative in the production of keloids it is suggested that trauma followed by some form of irritation at the site of injury are necessary in a susceptible person for the production of keloid.
4. A distinction has been made between keloid and hypertrophic scar both as regards pathology and treatment.
5. An outline of treatment is given to meet the requirements in the South African Bantu. The peculiar conditions applicable to the Bantu require certain deviations from accepted methods of treatment in Europeans. For socio-economic reasons treatment must be complete in about 3 weeks. The dosage of irradiation is higher in the Bantu than that recommended for the European.
6. In cases requiring skin-grafting after excision of keloids, the donor areas should receive prophylactic irradiation.
7. It has been suggested that, under existing circumstances, the most adequate treatment is the combination of excision and irradiation. The total irradiation dosage is about 2,000 r. This may be divided into 800 r pre-operative and 1,200 r post-operative; alternatively, the total dosage may be given post-operatively commencing on the 10th day after the operation.

We wish to thank Professor W. E. Underwood for his encouragement and criticism of this work. We are indebted to Drs. M. Shapiro and L. Cohen of the Radiotherapy Department, Johannesburg Hospital, for their co-operation and the performance of the irradiation, and to Dr. I. Webster of the South African Institute for Medical Research for the histological preparations used in this study.

REFERENCES

- Levitt, W. M., and Gillies, H. (1942): *Lancet*, **242**, 400.
 Pfahler, G. E., and Keefer, G. P. (1948): *Amer. J. Roentgenol.*, **59**, 378.
 Jacobsson, F. (1948): *Acta radiol.*, **29**, 251.



Fig. 4. Typical overhanging umbilicated keloid of eight years duration.

Fig. 4 (a). Three years after excision and application of 2,000 r post-operatively.

THE TREATMENT OF DIARRHOEA IN YOUNG CHILDREN AND INFANTS

A CRITICISM OF THE ROUTINE USE OF KAOLIN

FRANK ROUSSEAU, M.B., Ch.B., D.C.H.

Paarl, C.P.

The constipating properties of kaolin are well recognized and its use has become a routine in the treatment of diarrhoea. At a meeting of the Cape Western Branch of the Medical Association some months ago, I challenged the view that its effects were beneficial or desirable in the treatment of diarrhoea in young children, and expressed the opinion that the treatment of diarrhoea by means of constipating measures was irrational, being in conflict with the efforts of nature to eliminate toxic and undigested contents from the bowel. I stressed my opinion that the routine use of kaolin was not only undesirable but dangerous, and that if in its stead an enema syringe was used efficaciously to wash out the bowel this would help to reduce the high mortality rate from gastro-enteritis. This point was again raised at a recent meeting of the Branch.

The reduction in the mortality rate from gastro-enteritis during the last decade has been largely due (1) to increased knowledge of infant feeding and (2) to the use of intravenous saline infusions in the treatment of dehydration. Sulphonamides have proved rather disappointing, and their use has not contributed to any large extent to the improvement. On the contrary, where sulphonamides are employed together with a constipating agent, with disregard of the time-honoured treatment of purgation followed by starvation, the results have been disastrous. This result was to be expected, since we know that the treatment of an abscess (I do not think the analogy irrelevant) with antibiotics is useless without surgery, but where adequate drainage is allowed, whether in diarrhoea or an abscess, then sulphonamides have a definite place in the treatment.

The mortality rate, though lowered, remains alarmingly high. In fact gastro-enteritis is one of the chief causes of the death rate in infants, which is higher than that of any other age-group.

When our grandfathers used castor oil followed by starvation in the treatment of diarrhoea their results were not very much worse than ours are today. When constipating measures were added to the treatment by the use of one of the opiates we were warned never to use it in young children if the tongue was coated, if there was fever, or if there was dehydration. Opium has now been practically abandoned and replaced by kaolin, with which the bad effects of constipating are not quite so noticeable. Unfortunately the initial purging dose of castor oil is also being gradually abandoned. The routine use of kaolin continues as one of the few remaining examples of medical treatment in opposition to nature's own efforts. The practitioner is being bombarded by the many mixtures of kaolin and antibiotics that are put on the market. Chemists sell 'diarrhoea mixture', and the patient is confused concerning the place of a medicine in the treatment of diarrhoea.

CAUSES OF DIARRHOEA

The chief causes of diarrhoea in young children as encountered in general practice are the following:

1. Some indigestible or noxious substance ingested, e.g. paper, sand, peanuts, fruit skins and pips, are frequently the offender, giving rise to colic and diarrhoea. In infants too strong a feed will fall into the same category. (It is worth noting that the feeding charts accompanying most dried milks are on the strong side and, whilst tolerated by most infants, lead to a digestive breakdown in many.) Kaolin obviously has no place in the treatment here.

2. Thrush, if untreated, may spread down the oesophagus and result in diarrhoea which resists all treatment unless the cause is recognized and treated. This is the cause of a large proportion of the cases of diarrhoea seen in the general practitioner's consulting room, and here too kaolin can have no good effect.

3. Excessive administration of teething powders will cause diarrhoea, for most of these preparations contain calomel. This is the origin of the misconception that teething causes diarrhoea. Again kaolin is not the correct treatment.

4. Gastro-enteritis proper, as a cause of diarrhoea, may be an initial infection, but just as often is a complication of one of the above conditions, where the bowel has already become susceptible and the child's resistance lowered.

True, in gastro-enteritis the greatest immediate threat to life would be the onset of dehydration, and one feels that the diarrhoea must be stopped at all costs. Yet how often is the dehydration overcome by intravenous drip, and the diarrhoea checked by kaolin, and still the infant dies—from toxemia! This will be almost a daily occurrence in our hospitals during the next few months.

How often does the G.P. administer kaolin and diminish the number of stools without stopping the diarrhoea, which persists day after day till he is at his wits' end, not knowing how much longer he dare continue with starvation!

When the intestine contains an irritant, whether it be sand or bacterial toxins, it will respond in the same way as the eye, by pouring out fluid in order to wash itself free of the irritant. Would not the rational treatment be to assist nature in its attempt by washing out the bowel instead of holding back its contents? If the bowel has been completely emptied and all foods withheld the diarrhoea must stop and will do so more effectively than can be achieved with kaolin.



DIAMOX^{*}

ACETAZOLEAMIDE

Lederle

NEW SAFE ORAL DIURETIC

DIAMOX, Acetazoleamide, is a new, potent, yet safe oral diuretic which represents an important step forward in the control of cardiac oedema. It is easily administered, and oedema fluid is eliminated with safety. It is a remarkably non-toxic inhibitor of carbonic anhydrase. DIAMOX has been intensively tested clinically, and studies have shown that many cases of cardiac oedema previously requiring mercurials have been maintained oedema-free on DIAMOX alone. It allows for steady rather than intermittent control and has the following special advantages in general practice:—

Not a mercurial or xanthine derivative

A single dose induces profuse diuresis for 6—12 hours

It is potent yet remarkably safe

Suitable for regular use at home

Permits undisturbed sleep at night

Neither a gastro-intestinal nor renal irritant

For the long-term treatment of cardiac oedema

DOSAGE 1-1½ tablets orally each morning
or every other morning according
to the patient's weight.

PACKING: Scored tablets
of 250 mg. Bottles of 25
and 100.

LOOK TO



LEDERLE LABORATORIES DIVISION

Cyanamid Products Ltd.

Literature on request
* Regd. Trade Mark

FOR LEADERSHIP BUSH HOUSE · ALDWYCH · LONDON, W.C.2 · TEMPLE BAR 5411

Sole Distributors in South Africa:

ALEX LIPWORTH LTD., 120 JEPPE STREET, P.O. BOX 4461, JOHANNESBURG



• **ASTHMA**
• **BRONCHITIS**
• **EMPHYSEMA**

are rapidly relieved by the

Bronchovydrin

**INHALATION
THERAPY**



DRITAX HAND INHALER

BRONCHOVYDRIN is a specially balanced Adrenaline technique obviating parenteral injections and free of any secondary effects, yet affording dramatic relief of all forms of bronchospasm, whether physical, nervous or allergic.

Available with or
without a Face Mask

RIDDELL

Available in cartoned bottles of 12.5 gm.

Inhalers

SUPER PAG is a large table model and can be supplied with single or double bulb, also with bakelite stand.

2



SUPER PAG HAND INHALER

PNEUMOSTAT ELECTRIC INHALER is suitable for AC-DC of 90-110 volts or 200-250 volts, and is supplied complete with two **SUPER PAG** Inhalers either of which is brought into use by a two-way tap

RIDDELL INHALERS deliver a fine degree of dry atomisation in the region of 20 microns, which is absorbed by the alveoli with extreme rapidity affording relief to an **ASTHMA** attack within the matter of seconds and yet is very easily administered by the patient without inconvenience.

Please write for technical data.

3



PNEUMOSTAT ELECTRIC INHALER

Sole
Manufacturers

RIDDELL PRODUCTS LIMITED

RIDDELL HOUSE, 10-14, DUNBRIDGE STREET, LONDON E.2.

South African Representatives: **FASSETT & JOHNSON LTD.**, 72 SMITH STREET, DURBAN.

Phone: 2-9521

Please Support Our Advertisers — Ondersteun Asseblief Ons Adverteerders

170,000 HYPERTENSIVES

It is estimated that there may well be this number of European Hypertensives in the Union. The number of African sufferers is unknown but the percentage will be high among the de-tribalised types, striving to adjust to the pace of modern industrial life in urban surroundings. Returning to the Europeans, there must be an average of about 28 Hypertensive subjects to every practising Doctor. If only one quarter present themselves for treatment you probably have at least half a dozen on your books.

EACH ONE PRESENTS AN INDIVIDUAL PROBLEM, BUT EFFECTIVE THERAPY IS NOW SELECTIVELY AVAILABLE TO MEET THE PARTICULAR REQUIREMENTS OF EVERY CASE.

Veriloid

For positive hypotensive action orally or parenterally.

Veriloid-VP

To replace oral veriloid where higher dosage levels are indicated or where side effect of nausea is present.

Rauwiloid

Mild, long-acting hypotensor with added calming and bradycardic action.

Rauwiloid + Veriloid

For positive hypotensive effect under direct control of clinician plus rauwolfia virtues in addition.

Rauwiloid + Hexamethonium

Powerful, immediate acting hypotensor where the situation is judged to justify ganglionic blockade.

Further information available from:

3377-3

RIKER LABORATORIES AFRICA (PTY.) LTD. P.O. Box 1355, Port Elizabeth

LOS ANGELES

TORONTO

LOUGHBOROUGH



TOGETHER PENICILLIN & STREPTOMYCIN ATTACK

a wide range of gram-positive
and gram-negative bacteria—often assisting each other
in dealing with the more obstinate organisms

and together they are in

SECLOMYCIN*

Trade mark

In one injection Seclomycin provides the combined antibacterial activity of both procaine and sodium penicillin plus streptomycin. Here is a "broad spectrum" preparation in the truest sense, exerting a powerful attack on infections of mixed bacterial origin—typically, peritonitis, infected wounds, and infections of the urinary tract.

* Dry powder for preparing aqueous suspension

Prepared as directed, single-dose vials contain 300,000 units procaine penicillin, 100,000 units sodium penicillin and 0.5 gram streptomycin sulphate.

you feel you almost live there . . .

The number on the door is all too familiar . . . and so is the youngster. "He's run-down again, doctor . . . just like last month"—and so it goes on. And back you go again and again. But need you? *Minadex* does much to solve the problem of the run-down, debilitated child.

By replenishing the blood's reserves of essential minerals and by ensuring an adequate intake of protective vitamins A and D, *Minadex* staves off fatigue and fortifies resistance to infection through the *natural* mechanisms.



Minadex

Orange-flavoured mineral-vitamin tonic

In 6-oz. and 80-oz. bottles

GLAXO LABORATORIES (S.A.) (PTY.) LTD., P.O. BOX 9875, JOHANNESBURG
AGENTS: M. & J. PHARMACEUTICALS (PTY.) LTD., P.O. BOX 784, PORT ELIZABETH.



On the above rationale I have for the past 4 years entirely stopped using kaolin and have employed the following treatment with gratifying results. I have had no fatal cases of gastro-enteritis for 3 years despite the fact that hospital facilities for Coloured children have been practically non-existent.

THE TREATMENT OF DIARRHOEA IN GENERAL PRACTICE

1. Where the general condition of the infant appears to be good and there is no imminent danger of dehydration, I use purging followed by starvation, and one of the sulphonamides. Castor oil is the purgative of choice because it causes a rapid clearance of the bowel followed by a tendency to constipation.

2. Proper explanation to the mother of the principle underlying the treatment is most important. One so often comes across the mother who will not take her child off food because she thinks it is hungry and needs nourishment, or the mother who has obediently been giving the glucose or barley water the doctor ordered, but has not been withholding milk because she has not been told to. At the other extreme in some of the worst cases of malnutrition I have encountered, the infant has been on barley water for weeks because the busy practitioner has forgotten to tell the mother that this is only a temporary measure. One should not lose sight of the fact that the highest death rate is amongst the ignorant, and therefore time spent on carefully instructing the mother is not wasted. She should be told that a sick tummy must be completely rested before it can recover and continue its work, and that it can only rest when completely empty; that food and milk will only be nauseating to the child and cause cramps; but that he will be very thirsty and sugared water can be given often and plentifully, or in frequent small sips if vomiting persists. We have lately become very electrolyte-conscious, and it is advisable to instruct her to add a little salt as well.

3. Where diarrhoea has been going on for several days, or dehydration threatens, I do not give castor oil but resort instead to the enema syringe.

Technique of the bowel wash-out. The most effective type of syringe is the one which sucks water through the non-business end. A waterproof is placed over the edge of the bed and covered with a towel. A bucket or bath is placed underneath to receive the washings. The infant is placed on the towel with buttocks projecting over the edge of the bed whilst someone flexes and holds up his legs. The suction end of the syringe is placed in a jug containing luke-warm water with one teaspoon of salt or sodae bicarb. added for every pint. Care is

taken to expel all air from the syringe before inserting it, for the injection of air appears to cause pain. It is also wise, once the nozzle is in place, to cover it with a towel, because the washings may otherwise shoot for quite a distance across the room. Pint after pint can be pumped into the infant without removing the nozzle and with disregard of the pressure exerted on the bulb, for the peristaltic movements set up will eject the bowel contents past the nozzle. In order to be effective this treatment must be carried out thoroughly and I usually use a total of about 8 pints. It is interesting to measure the amount of water returned at the end of the operation and note what a surprising amount has actually been retained by the infant.

If the infant is severely dehydrated and, as is so often the case, no hospital bed is available, I give an intraperitoneal infusion of boiled but sufficiently cooled water, employing an ordinary lumbar-puncture needle. This is done before washing out the bowel. In such cases I make it plain to the mother that the rest is up to her and that she must administer water containing salt and sugar at 10-minute intervals throughout the night. The mother will do what no nurse is able to do for her infant, and invariably the following morning reveals a fully-hydrated and perky infant, and a tired but grateful mother.

Gastro-Enteritis with Acidosis. This is one of the pitfalls of paediatrics. The infant is usually fat so that it does not appear obviously dehydrated except for sunken eyes. It appears ill in a toxic sense and the respirations are rapid. The case is easily mistaken for one of pneumonia. The history of a rapid succession of watery stools—usually without vomiting—and the fact that the respirations, though rapid, are not shallow or grunting, but deep and not pneumonic in nature, should reveal the true diagnosis. In these cases both the wash-out of the bowel and the intravenous administration of glucose and saline solutions are a matter of urgency.

SUMMARY

Reference is made to:

1. The advances in the prevention and treatment which have contributed to the lowering of the mortality from gastro-enteritis.
2. The chief causes of diarrhoea in young children.
3. Criticism of the use of kaolin as a routine measure in the treatment of young children for diarrhoea.
4. The treatment of diarrhoea in young children by means of a bowel wash-out instead of constipating with kaolin.

INTERNATIONAL DIABETES CONGRESS

International Diabetes Congress. The Second International Congress of the International Diabetes Federation will be held at Cambridge, England, on 4-8 July 1955, under the Honorary Presidency of Sir Lionel Whitby, C.V.O., M.C., Professor of Physics, Cambridge. The congress will be open to official delegates of Member Associations and others, medical and lay, who are interested in diabetes. The official languages will be English and

French, and abstracts of papers will be printed in those languages. Those desirous of reading papers, which must not take longer than 20 minutes in reading, must send to the Organizing Secretary abstracts limited to 350 words not later than 31 December 1954. Accommodation will be available in 9 colleges of the University and at hotels. Congress office (before Congress), 152 Harley Street, London, W. 1.

CASE REPORT : SEVERE ACUTE BARBITURATE POISONING IN A CHILD, SUCCESSFULLY TREATED WITH AMPHETAMINE SULPHATE AND Picrotoxin

B. SEFTTEL, M.B., CH.B.

Fish Hoek, Cape

In view of the universality of the use of the barbiturates in modern society the following report of an accidental case of poisoning in a child, successfully treated, is considered to be of value and interest.

A European child, aged 2 years and 8 months, accidentally ingested a quantity of phenobarbitone, estimated at 50 grs. The circumstances of the poisoning were as follows:

On 1 April 1953 at about 10.30 a.m. the mother gave the child one phenobarbitone tablet (gr. $\frac{1}{2}$) out of a bottle known to contain at least 400 tablets. The bottle was then left on a window shelf and the mother left the house to visit a neighbour. On her return at about 11.15 a.m. she found the child semi-comatose. The bottle, found open where she had left it, now contained about 200 tablets. No loose tablets could be found in the vicinity.

The child was admitted to hospital at 11.45 a.m. Condition on admission: coma, shallow respiration, blood pressure 90/60 mm. Hg, pulse 100, and pupils contracted and showing no reaction to light.

Treatment was initiated by washing out the stomach. Coramine 1 c.c. and amphetamine sulphate 5 mg. were injected intramuscularly. The administration of oxygen was then commenced by means of a Boyle's machine with an air-tight facepiece and a partially closed valve. Penicillin (500,000 units 8-hourly) was also started. Amphetamine sulphate was given 2-hourly in doses of 10 mg., subcutaneously with hyalase, together with coramine 1 c.c. Oxygen therapy was maintained and at 10 p.m. lumbar puncture was performed.

At this stage (12 hours after admission), in spite of deep coma, there appeared to be some response to treatment. The pupils were moderately dilated, the blood pressure was 120/60 mm. Hg, pulse 160, respiration 40 and temperature 100° F.

In the following 24 hours amphetamine sulphate 5 mg. and coramine 1 c.c. were given 6-hourly (subcutaneously with hyalase). This dosage was obviously inadequate. All day on 2 April coma remained deep, all reflexes were absent and the pupils were contracted. Respirations, however, were rapid and the pulse was 160.

At this stage (36 hours after admission) an intravenous drip of 5% dextrose in saline was started and lumbar puncture repeated. Picrotoxin, starting with a 2-mg. dose increasing progressively to 6 mg., was given intravenously at 15-minute intervals up to a total of 60 mg. Amphetamine sulphate 10 mg. was also administered intravenously every 3 hours up to a total of 40 mg. During this phase of treatment there was some response to painful stimuli, colour was good and respiration was rapid, as was the pulse rate.

Forty-eight hours after admission, the child could be roused to crying by painful stimuli. Eyeball activity was present, and also the corneal reflex. Intravenous therapy was now stopped. A Ryle's tube was passed and a gastric feed of citrated milk, with one 5-mg. tablet of amphetamine sulphate was started.

Sixty hours after admission the child was fully conscious, and asked for water and drank a full glass.

Seventy-two hours after admission, the temperature and pulse were normal. An enema was given and in the faecal result undissolved particles of tablets were present. Examination of the chest showed no abnormality; penicillin therapy was stopped on the 6th day. The patient was discharged on the 10th day, fully recovered.

DISCUSSION

This case emphasizes the need for active and persistent treatment in barbiturate poisoning. A false sense of

security may be felt on observing the state of coma, for the absence of cyanosis or Cheyne-Stokes respiration may give the impression that the patient is merely in a deep sleep. If active treatment is not instituted without delay, death may occur from respiratory depression, usually with a terminal bronchopneumonia or pulmonary atelectasis.

Treatment in this case consisted of:

A. Supportative measures, i.e. continuous oxygen and parenteral fluids

B. Lumbar puncture

C. Prophylactic penicillin therapy

D. Stimulants

(a) *Amphetamine sulphate*, as a drug useful in counter-acting barbiturate poisoning, was first suggested by Myerson.¹ Freireich and Landsberg² reported on 14 cases with favourable results. Its effect would appear to be two-fold, viz. sympathomimetic and wakeful-psychologic. The sympathomimetic action is shown by a rise in blood pressure, increase in rate and depth of respiration and increase in pulse rate. In its wakeful-psychologic effects, it specifically counteracts the soporific effects of the barbiturates. The reciprocal pharmacological action of amphetamine sulphate and barbiturate allows for the use of much larger doses of amphetamine sulphate than one could administer to a person under normal physiological conditions.

(b) *Picrotoxin* has been used extensively with favourable results, yet it would appear to leave something to be desired in the treatment of the deeply comatose patient. In a report of the Council of Pharmacy and Chemistry of the American Medical Association³ the following statement is made: 'The details of events in the course of animal experiments show that it is necessary to poison the animal with picrotoxin in order to elicit the antagonism. What results when the two drugs are given together is not a direct reversal of the depressed state, but a combined form of poisoning by picrotoxin and the barbiturate, with a mixture of depression and stimulation from which, within a given range of doses, the animal ultimately recovers'.

(c) *Coramine*. The treatment of coma from barbiturate poisoning still taxes the therapeutic skill of the physician. The evaluation of any one drug used in treatment is difficult, as the individual response to different doses of barbiturate is so variable. In the case reported here it is the author's clinical impression that both amphetamine sulphate and picrotoxin played a useful role in stimulating activity and depth of respiration. Equally important was the skilled and constant attention of the nursing staff to the oxygenation of the patient, and the regular recording of treatment,

the patient's responses to stimuli, and pulse and respiration rates.

I wish to thank the Superintendent of the False Bay Hospital, Simonstown, for permission to publish this case, and also Dr. R. F. Maggs, Honorary Paediatrician of False Bay Hospital, for his advice in this case.

THE STORY OF THE ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS, 1929-1954

R. L. IMPEY, M.D., F.R.C.S. (EDIN.) F.R.C.O.G.

The history of the foundation and development of this College over its first 25 years has been recently published.* The founding of a College had been suggested on a number of occasions but nothing had materialised chiefly because the teaching and examination of these subjects were the prerogative of physicians and surgeons.

It was after the 1914-1918 war that the dream of a young Manchester gynaecologist, William Fletcher Shaw, started to become a reality, and the first steps were taken to found a new College. The difficulties seemed unsurmountable, and only those who worked with Fletcher Shaw at that time—as the writer of this review did—can realize what the Royal College owes to his enthusiasm, energy and determination.

To him the movement was a crusade to put obstetrics and gynaecology, the 3rd subdivision of medicine, into its rightful place. A similar tribute must be paid to Blair Bell, Comyns Berkeley, and Ewen Maclean, who with Fletcher Shaw were appointed by the Gynaecological Visiting Society as the first committee 'to explore the possibilities of founding such an organization'.

The main reasons for the formation of a College of Obstetricians and Gynaecologists were:

(1) To form a portal through which must pass all who wished to be consultants in this branch of medicine, that portal to consist of equal parts of training and examination.

(2) To prevent the divorce of obstetrics from gynaecology.

(3) To bind the teachers of obstetrics and gynaecology together so that they could demand adequate facilities for the teaching and examining of students.

(4) To speak as the representative body of all obstetricians and gynaecologists.

The chief opposition to the formation of this new College came from the two English Royal Colleges, which for long had dominated medicine in England. The opposition of these Colleges arose from a real difference of opinion about the conduct of qualifying examinations. The Conjoint examination at that time was very much the province and the property of the two Colleges, which they very naturally wished to safeguard. They thought the emphasis placed on midwifery in the Final Conjoint examination was correct, while those who founded the new College made no secret of the fact that they considered the midwifery portion of this examination most unsatisfactory.

Fortune, however, played into the hands of the new College. The Government had made improvement in maternal mortality a plank in its political platform. On being persuaded that the only way to achieve a permanent reduction in maternal mortality was to improve the teaching and training of medical students and graduates, Neville Chamberlain, then Minister of Health, invited Professor Blair Bell, of Liverpool, and the Presidents of the two English Royal Colleges to meet in conference at the Ministry of Health. As a result of this and other meetings, the opposition of the two Colleges was finally withdrawn, and the British College of Obstetricians and Gynaecologists was registered as a Company on 13 September 1929.

Since then the relations between the older and the new Colleges have grown steadily closer and more amicable, and in 1942 a Standing Joint Committee of the three Royal Colleges in London came into being.

Professor Blair Bell was elected first President of the College, and it is due to his phenomenal ability, energy and foresight that the progress of the College has been so rapid. Within 2 months of its registration the Minister of Health had consulted the President and asked him to draw up and submit a scheme for a maternity service for the country. By degrees the new College was consulted more and

REFERENCES

1. Myerson, A. (1940): *Amer. J. Med. Sci.*, **199**, 729.
2. Freireich, A. W. and Landsberg, J. W. (1946): *J. Amer. Med. Assoc.*, **131**, 661.
3. Report of the Council on Pharmacy and Chemistry of the American Medical Association (1939): *J. Amer. Med. Assoc.*, **112**, 431.

more, until now all questions bearing on obstetrics and gynaecology are referred to it almost as a routine.

Training and Examinations.

The new College when framing its constitution had the advantage of the experience of the older institutions, and was free to adopt what seemed good in the old ones and to discard the archaic. It was decided to have both Fellows and Members but, unlike that of either of the English Royal Colleges, the test for membership would consist as much of training as of examination. There had been several instances in the past when men with an F.R.C.S. who had not held even a junior appointment in a maternity department were made professors of obstetrics. The College is responsible for the passing of those 'bad old days' when such appointments were possible, and now, before sitting for the Membership examination, 3 years' resident appointments in obstetrics and gynaecology are required, and the M.R.C.O.G. has become the standard diploma for those applying for senior posts as obstetricians and gynaecologists. The College also makes provision for a Diploma in Obstetrics for general practitioners, and practical training and a resident appointment are required before this examination may be taken.

The Dominions.

The Dominions form an important part of the College, and with this in mind the College was christened the British College of Obstetricians and Gynaecologists. Although Australia has its own Royal College of Physicians and Royal College of Surgeons, a Regional Council of the British College of Obstetricians and Gynaecologists was established there in 1947, and is consulted by the Government and other bodies on matters appertaining to obstetrics and gynaecology. Canada has its own Royal College of Physicians and Surgeons combined but, in addition, has a Regional Council of the British College consisting of Fellows and Members who represent Canadian obstetrics and gynaecology. In 1951 a Regional Council of the College was set up in New Zealand.

South Africa has had a College Reference Committee since 1932, and a move is now being made to have this elevated into a Regional Council. Irrespective of whether South Africa has a Reference Committee or Regional Council, it is of fundamental importance that obstetrics and gynaecology should retain its individuality and maintain its position as the 3rd subdivision of medicine. History demonstrates the danger of putting this speciality under the control of physicians and surgeons, and it should always be kept in mind that the movement to form the British College was 'due to the neglect of obstetrics and gynaecology by the Royal Colleges'.

It is interesting to note the stimulating effect that the new College has had on the older institutions. The College introduced a completely new departure by insisting upon a period of training in resident appointments. No resident training had previously been required for any other higher medical diploma. The Royal College of Surgeons of England has since followed this example and demands a year of resident work in addition to the primary examination.

At an early date the College laid down minimum requirements for the hospital departments in which candidates for the Membership could hold resident posts. Hospitals soon found that, unless their obstetrical and gynaecological sections were recognized for the College examinations, difficulty was experienced in obtaining residents. This has resulted in considerable up-grading of many hospitals. As a result of the increasing reputation and authority of the College medical educationists have been compelled to allocate more time for the training of medical students and better facilities for examinations. Two months resident training in obstetrics for undergraduates is now almost universal, and the final examination

includes clinical, written, and oral tests. All this has been followed by an improvement in the standard of obstetrical and gynaecological practice throughout the country.

Finally, one criticism. The author frequently refers to 'the two Royal Colleges'. This is unfortunate. After all, the College of Obstetricians and Gynaecologists is a British College, and there are four Royal Colleges in Britain, as well as Royal Colleges in Ireland, Australia and Canada. The feelings of large numbers, particularly of those in the Commonwealth, were expressed by Blair Bell, the first President of the College, in a letter published in the *British Medical Journal* of 23 March 1929, in which he refers to the 'Royal Colleges of London', and states *inter alia*, 'There are, moreover, colleges elsewhere as important in the eyes of their disciples as are

the London colleges in the opinion of those of us who have the honour of belonging to them'.

This is a book that no obstetrician and gynaecologist can afford to be without. Further, it is suggested that as a new South African College of Physicians and Surgeons is in the process of being established, this history should also be of great interest and value to those who are responsible for its founding and development.

* *Twenty-five Years. The Story of the Royal College of Obstetricians and Gynaecologists, 1929-1954* by Sir William Fletcher Shaw, M.D., F.R.C.P., F.R.C.O.G., Hon. LL.D. (Pp. 192 + 7 with illustrations) £1 1s. J. A. Churchill, Ltd., 104 Gloucester Place, London, W1. 1954.

TWO INTERNATIONAL CONFERENCES IN SPAIN

INTERNATIONAL CONGRESS OF THE LEAGUE AGAINST TUBERCULOSIS

INTERNATIONAL MEETING OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS

DAVID P. MARAIS, M.D., F.R.C.P. (EDIN.)

Consulting Physician, Groote Schuur Hospital, Cape Town

Madrid, proud capital of a proud race, and the venue of the 13th International Conference of the League against Tuberculosis, was itself one of the principal attractions for the nigh three thousand delegates who gathered there from every quarter of the world. Set in an elevated plateau, like our Johannesburg, it surprises the visitor with its complete modernity, with its magnificent boulevards, its well-tended parks, its coronetted towers and its teeming, joyous life. Still showing many evidences of rapid regeneration and recovery from the destruction and paralysis of civil war, the city through its citizens welcomed the strangers with laughter and song and dance—and, of course, a bull fight—and sent them home with nostalgic longings for a repeat visit.

It would then be an understatement to say that the Congress was anything less than a great success—socially, as well as scientifically.

The Conference sessions ran with an orderly precision which afforded its participants a sense of satisfaction and accomplishment. The Inaugural Session took place in the splendid 'aula' of the Institute for Scientific Research, and was presided over by Generalissimo Franco, supported by several Generals and Ministers of State; the scientific sessions were held in one of the halls of the rebuilt University City—fully equipped for dealing with polyglot audiences.

Much preliminary work lasting over from the preceeding year, from principal and secondary reporters from many countries, formed the basis of the discussions, which lasted through 4 full days.

Three main aspects of Tuberculosis were discussed, viz. (1) the Social Question, (2) the Biological Question, and (3) the Clinical Question. All papers were printed and circulated to members on enrolment.

The following is a very brief summary of the proceedings, and indicates the main tendencies of the discussions.

THE SOCIAL ASPECT

The Argentine co-reporter found that 62.7% of cases admitted to institutions had been inadequately treated by general practitioners with antibiotics, and 70-80% of these became chronic cases with resistant organisms. They restated the resolution, accepted by the Pan-American Congress of 1953, which recommended that 'all Governments should take steps to prevent the indiscriminate use of antibiotics'. This was supported by Portugal, and to this the Belgian delegates also subscribed, but recognized difficulties in the control without restricting the rights of the general practitioners.

French delegates noticed the tendency to leave the sanatorium for continued treatment at home and the care of the specialist in favour of that of the general practitioner. This increased contamination risks and added to the financial burden.

The problem of the chronic case was a burning one in most countries. The German reporter felt that the following steps were important: (a) Isolated housing. (b) Seasonal stay in sanatoria. (c) Suitable employment and sufficient economic help. Therefore, early diagnosis becomes more important than ever, and all the procedures of preventive medicine should be employed and intensified.

Portugal suggested increased dissemination of technical information to the medical profession, compulsory notification, a more effective dispensary network, intensification of BCG inoculations, with after-care and rehabilitation as important factors.

Switzerland was concerned with the early detection of 'carriers' and their elimination by early treatment and systematic X-ray examination at regular intervals.

Sweden was concerned with the immediate treatment of meningitis and miliary tuberculosis. The discovery of primary tuberculosis in children under 2 or 3 years called for vigorous and adequate antibiotic and chemotherapeutic (A.C.) treatment, which might check miliary spread and obviate meningitis.

After meningitis 2 or 3 years of careful control was necessary to prevent relapse. Young, of Brompton Hospital, recalled Honor Smith's good results with tuberculin and streptomycin in meningitis, and noted similar good results of the combination in 40 cases of pulmonary tuberculosis admitted for major operations.

Prof. Blanco, of Madrid, in his principal report supplied an excellent statistical study on changes in the control of tuberculosis as the result of modern therapy. He discussed the discrepancy between morbidity and mortality figures; the number of new cases was decreasing slowly, but the tuberculous section of the population was increasing because of the prolongation of life of the chronic case. Every country reported that the mortality rate was tumbling (e.g. 82% for Finland in the last 25 years). The morbidity rate (new cases) was not declining much, sometimes even rising, and the number of chronic cases was rising.

The remedy was (a) to isolate all chronics, (b) to make as early a diagnosis as possible, and (c) to treat without delay by every method available. Several reporters pointed out that the main changes in epidemiology were (1) the shifting of the primary infection to a later age-group, (2) the shifting of a higher mortality to an older age-group, and (3) the marked reduction in tuberculous mortality in most countries.

At the same time some observers consider that we are now experiencing a milder form of tuberculosis than that of 50 years ago, and all agreed that the oscillations of mortality ran parallel with periods of welfare and crisis in all countries.

The United States observer considered that our present best methods were merely a change of emphasis in the settled campaign. Eradication would come through a general betterment of our mode of life, envisaging thus a new social order in which tuberculosis would secure no foothold.

THE BIOLOGICAL ASPECT

The biological question was admirably introduced in a valuable monograph by Dr. Georges Canetti of the Pasteur Institute, Paris, and well discussed by co-reporters from many countries. The macroscopic and microscopic changes in tuberculous lesions under A.C. treatment are described, and anatomical healing fully demonstrated.

Canetti draws attention to the occurrence of mycobacteria of varying degrees of drug resistance in the same patient, and this is confirmed by numerous observers. INH resistance emerges early in a high percentage (27%), but a combination of INH and streptomycin lowers the percentage of resistant forms, and largely abolishes the occurrence of organisms of varying degrees of resistance in the same subject. Virulence after a course of INH is considerably decreased. The degree and constancy of this is not yet known.

Xalabarder of Barcelona draws attention to the spontaneous fall in the malignancy of human tuberculosis in the last 20 years, and the spontaneous decrease in the virulence of T.B. strains. We must also take into account the fact that the germ exists under other non-bacillary and non-acid fast forms, which can themselves provoke the disease. Electronic microscopy shows that the mycobacteria are true mycetes and a final phase which we call Koch's tubercle bacillus. One of the effects of antibiotics is to arrest this evolution in one of the intermediate phases, but this does not mean that the germ dies; after a period of inactive evolution in a form invisible to the optical microscope, the classical acid-fast bacillary types may again reappear, and this form is indifferent to A.C.

Several observers note that virulence and streptomycin-resistance are two independent characters. Resistance to streptomycin, *in vitro* at least, occurs late and is permanent; resistance to INH occurs easily and is unstable.

Ibiapina of Brazil and Abello of Madrid describe the microscopic tissue-changes after the exhibition of streptomycin and INH. The latter causes active hyperaemia and oedema in the lesion, with clean resolution subsequently, while the former causes a fibrosing process. Under antibiotics the germs lose vitality and virulence progressively, and those with no virulence are doomed to disappear. Under similar treatment ulcerous lesions may heal cleanly, but still remain open; the mechanism of this is not known. Therefore, he presumes it is not only the mechanical factors—permeability of the draining bronchus—but some other biological factor, at present unknown, causing early and intense fibrosis and absence of granulation tissue. This leads him to favour early collapse methods and A.C. before resection.

Meissner of Germany and others felt that the best results of A.C. therapy occurred when the germs were in a 'stage of multiplication' and therefore particularly in early foci of disease. In action antibiotics were largely bacteriostatic, modifying the structure, disturbing the growth, and debilitating the virulence of the tubercle bacilli.

D'Esopo (U.S.A.) reported on his examinations of resected lungs. He found that after streptomycin alone cavity-closure was infrequent, because resistance develops more rapidly than closure, and that the drugs we now use do not kill bacilli in the concentrations we attain in the serum. He indicates the possibility that the metabolites of the closed lesions are more rapidly lethal to bacilli, which are, in addition, being inhibited by chemotherapy. As the result of A.C. therapy he notes the following: (1) more or less complete resolution of non-necrotic lesions, (2) absence of change in solid necrotic lesions, and (3) frequent closure or filling-in of cavities.

Prolonged streptomycin and PAS in 10% of lesions still show non-viable T.B. In open cavities T.B. are found viable more frequently; non-viability is, he thinks, related to the closed state of the lesion rather than to chemotherapy.

Reginster of Belgium is supported by Iwasaki of Japan in pressing for a daily (1 g.) dose of streptomycin plus INH or PAS, rather than the semi-weekly dose. This is specially important in early, progressive tuberculosis. In less progressive disease both regimens are equally effective.

THE CLINICAL ASPECT

The clinical aspect was vigorously and ably discussed. All prominent surgeons—Crafoord of Stockholm, Semb of Oslo—show great care in the selection of the correct type of surgical procedure

for each case, and there was general agreement that, as Zorini put it, it was unfair to compare the long-time results of the smaller surgical interventions—artificial pneumothorax (A.P.) and extra-pleural pneumothorax (E.P.)—without antibiotics, with the immediate results of resection with antibiotics and chemotherapy.

Opinions swung between the extremes of enthusiastic resection (Eerland and Kraan, Holland, and Berard, France) to the caution of Heilmeyer (Germany), Zorini (Italy), Alarcón (Mexico) and others who favour more conservative methods. Well-balanced reports, revealing logical attitudes after long experience, came from Vaccarezza (Argentina), Alarcón (Mexico), Marques Blasco (Spain), Laos (Peru) and others. The importance of the preservation of pulmonary function after any operative interference in the thorax was generally admitted, and the need for full cardio-respiratory function-tests in all cases, before and after operation, were duly emphasized.

There was general agreement that well-established conservative methods—rest, antibiotics, etc.—must always precede active interference by minor or major surgical procedures. Many reporters favoured the simpler methods—artificial pneumothorax (A.P.), pneumo-peritoneum (P.P.)—which were being discontinued without reason in some quarters. The objections to A.P. have largely disappeared with the shortening of the treatment by A. and C. and modified techniques. Bilateral A.P. has disappeared in favour of P.P. Pleural adhesions are only sectioned if the pleura is found healthy, since the pleural complications (empyema, symphysis), with thickening and lung splinting, are to be avoided at all costs. Extra-pleural pneumothorax under correct indications is much favoured (Vaccarezza, Zorini, Crafoord, Alarcón and others). The indications for thoracoplasty are much reduced because of the inevitable loss of lung function subsequently, and the operation is best reserved for the upper and posterior segments.

Stattler of Vienna made a strong plea for pleural endoscopy as a diagnostic procedure to distinguish tuberculosis from carcinoma. Using a 120 thoroscope, he has produced some beautiful colour pictures of the pleura in health and disease.

On the absolute indications for resection of the lung there was fairly general agreement. Alarcón gives the following: (1) Failure of thoracoplasty and other methods, (2) 'destroyed' lung, (3) fibrothorax with cavities and/or bronchiectasis, (4) bronchiectasis associated with tuberculous cavities or fibro-caseous disease, (5) tuberculoma of more than 2 cm. diameter, (6) bleeding cavities, uncontrolled by collapse therapy, (7) filled-in cavity, larger than 1 cm. in diameter, and, Vaccarezza would add, tuberculous empyema with bronchial fistula.

Ascertained drug resistance should incline one towards collapse therapy. Pre-operative treatment should be done with a combination of PAS and INH, leaving streptomycin for use before and after surgical intervention. On the face of the dangers of the development of drug resistance several reporters, like Eerland, feel strongly that A.C. treatment should not be given by the general practitioner, but must be left in the hands of experienced tuberculosis specialists. This seems to be officially recognized in the Netherlands.

Maurice Gilbert (Switzerland) briefly sums up his attitude: The real cure with A.C. can no longer be relied on when tuberculosis is past the chronic stage or when, from the onset, it has taken on a fibrous form. But A.C. must be used in the framework of general treatment. Where there is ulcerous or stenosing bronchial tuberculosis A.C. cannot cure, but radical surgery must take place.

AMERICAN COLLEGE OF CHEST PHYSICIANS

The Madrid Conference was followed immediately by the Third International Meeting of the American College of Chest Physicians at Barcelona. At this the range of enquiry embraced all thoracic disease—cardio-vascular, pulmonary and oesophageal—and brought together some 1,200 delegates from 80 countries. Simultaneous sessions in 3 adjoining halls were held and a daily 'quiz' session with a panel of carefully selected 'authorities' before the general audience was most popular. In the hands of a good chairman or 'quiz-master' such a panel can be of the greatest interest and benefit to the general practitioner as well as the specialist and might very well be incorporated as a feature in our own Medical Congresses.

To be successful and useful to specialist and general practitioner alike, our congresses should carry the following regulations: 1. A strict time limit to be imposed on all speakers. 2. Papers

to be previously printed and not to be read, but authors to be allowed 10-15 minutes to state their findings and illustrate results. 3. Extension of time may be granted by the chairman of the session if requested by the audience. 4. The panel system ('quiz') set up of men prepared to answer with authority questions carefully

arranged and submitted previously to them. Questions may be submitted by the audience on timely notice. These features can greatly speed up and increase the range of usefulness of our Annual Meetings, and leave the participants with a greater sense of satisfaction after this more intimate exchange of views.

EXAMINATION FOR DEGREE OF M.B., B.CH., UNIVERSITY OF THE WITWATERSRAND

The Registrar of the University of the Witwatersrand, Johannesburg, announces that the following candidates have completed all the requirements of the Sixth Professional Examination for the degree of M.B., B.Ch.:

Awath-Behari, K.
Bader, L. V.
Barnett, A. M.
Bernstein, L.
Berson, S. D.
Blumenau, J.
Blumsohn, D.
Borkon, L.
Boshoff, P. J.
Brozin, I. H.
Calinikos, J.
Campher, E.
Catterall, R. D.
Charlton, O. P.
Combrink, P. B.
Deane, R. S. D.
de la Harpe, P. L.
Dove, J.
Edelstein, W.

Fain, H. R.
Freeman, N. V.
Friedman, S.
Gamsu, H. R.
Geocelter, L.
Getz, G. S.
Gien, L. E.
Gold, J. I.
Goott, B.
Gordon, E. D.
Gravett, D. C.
Green, J. R.
Gross, F.
Gunn, F. P.
Harrison, P. M.
Herberg, L. J.
Jackson, F. M.
Jankowitz, D.
Karim, A. R.

Karlsson, E. L.
Keeton, G. R.
Khatir, N. J.
Klein, A.
Kleiner, J.
Klugman, S. N. P.
Kushlick, A. R.
Law, I.
Lee, F. P.
Le Hellico, H. E.
Le Pere, R.
Liang, D. Y. S.
Louw, J. X.
Lundie, M. J.
Luntz, A.
MacCrone, E. M.
Manakos, N.
Matthews, N. D.
Mbete, C. W.
Miller, F.
Mitchell, J.
Mokhesi, C. P. N.
Monk, C. J. E.

Morris, E.
Motlana, H.
Mottiar, Y.
Nyoka, P. P. S.
Osrin, M. Z.
Parsons, J. A.
Phillips, B.
Posel, C. F.
Ribane, S. M.
Sash, L.
Schultz, E. L.
Seaward, P. D.
Sneider, P.
Stoch, E. M.
Taylor, G. M. L.
Taylor, R. K. N.
Utian, H. L.
van Straaten, B. J.
Vawda, E. I.
Viljoen, W.
Waters, H. G. F.
Wilker, C. U. E.
Yazbek, H. I.

THE HIGHLY RESPECTABLE PRACT-TISH-ON-ER

With apologies to W. S. Gilbert.

For those who would like to make a song about it, the music has kindly been supplied by Sir Arthur Sullivan.

When I left 'coll' and started here,
A young disciple of Galen,
I had to study the Pharmacopoeia
To raise the sick from their humble bier
And bring a smile and a word of cheer
To whoso might be ailing.
Now all my thoughts were kind and true
And people thought me clever,
Of that there is no manner of doubt,
No possible probable shadow of doubt,
No possible doubt whatever.

The public saw my nice black bag
And stethoscope bright and shiny.
Their faith in me would never flag,
They listened to a long chin-wag,
And I prescribed some sulphate mag.
Or perhaps a trip to the briny.
And if and when their end would come
I buried them deep forever,
Of that there is no possible doubt,
No possible doubt whatever.

But then one day a man called in,
A suave and fluent fellow,
And I learned to worship at Bicillin,
The latest disease was Histamine,
And cures for all were in a tin
Of capsules blue and yellow.
If the patient lived to pay the price

He sure was broke forever.
Of that there is no possible doubt,
No possible doubt whatever.

With Sulpha drugs I was now *au fait*,
I prescribed them with enthusiasm.
Then Aureomycin came my way,
To folk who had the *geld* to pay,
I ordered bucketsful every day,
Whatever their pain or spasm,
Gastritis, goitre or even gout,
Favus, fistula, bilary fever,
Of that there is no possible doubt,
A Mycin was the answer.

Now I'm much inclined to fear
My mind is all chaotic,
I've quite forgotten the Pharmacopoeia
And can never declare with a mind sincere
If it's a case of leucorrhoea
Or if its antibiotic.
But the Readers Digest has helped me lots,
I prescribe from it forever.
Now that's my tale quite free from doubt,
All possible probable shadow of doubt,
I swot catalogues now forever.

A. Kingsley-Hall

P.O. Box 108
Burghersdorp, C.P.
14 November 1954

Where do you find ATHLETE'S FOOT?

Despite the implication in the name, athlete's foot is more prevalent amongst the non-players than it is amongst players, to all of whom care of the feet is of primary importance. The introduction of Mycil, the new fungicide developed in the B.D.H. Research Department, has made available to medical men a highly effective preparation for prevention and treatment of this widespread infection. Mycil is available as Mycil Ointment and Mycil Dusting Powder.



MYCIL

TRADE MARK

BRITISH DRUG HOUSES (SOUTH AFRICA) (Pty) LTD.
123 Jeppe Street Johannesburg

Myc/SAP/6

Mr. F. Bosman, holder of The Old Mutual's Millionth Policy

says: "For the past 80 years, there have been members of the Bosman family insured with THE OLD MUTUAL."



Family tradition helps build the Old Mutual:

It is people who cause events that make history. For 108 years it has been the South African people — generation after generation — who have built the Old Mutual into the greatest mutual assurance society in South Africa.

The Bosmans are one of the many South African

families whose names run like threads through the history of the Old Mutual . . . Cloete, Melck Baxter, Fourie . . . for generations these families have found security and peace of mind by insuring with the oldest mutual assurance society in the land — the Old Mutual.

There's a "Man from the Old Mutual" in your area. Call on him and you'll discover how little it costs to have complete security for you and your family.

THE OLD MUTUAL

SOUTH AFRICAN MUTUAL LIFE ASSURANCE SOCIETY

Your Friend for Life


SOUTH AFRICA'S OLDEST AND LARGEST LIFE ASSURANCE OFFICE
Associate Office of fire Accidents and Marine Insurance The South African Liberal Insurance Company Limited
G7-26



THE PROBLEM OF ASTHMA

A search for the causative origin of asthma can indeed be a tedious one, but always the underlying factor—BRONCHOSPASM—can be treated immediately with FELSOL. Physicians in all parts of the world to which it has been introduced, have for years relied implicitly on FELSOL for the instant relief it gives in an attack of asthma no matter what the basic cause. FELSOL acts directly on the bronchial musculature and indirectly through the vagus and sympathetic.



Rapid in action—Prolonged in effect

Full relief in perfect safety

Clinical sample and literature on request

MACDONALD, ADAMS & CO.
21 KERK STREET, JOHANNESBURG

BRITISH FELSOL COMPANY LTD., 206/212 ST. JOHN STREET, LONDON, E.C.1

Please Support Our Advertisers — Ondersteun Asseblief Ons Adverteerders

ASSOCIATION NEWS : VERENIGINGSNUUS

MEETING OF SOUTH EASTERN DIVISION OF CAPE WESTERN BRANCH

At a meeting of the South Eastern Division of the Cape Western Branch held on 16 October 1954 at Mossel Bay, Dr. J. J. van Reenen, President of the Division, delivered an address in which he looked back on his 30 years of general practice and gave a most interesting synopsis of the gradual change that has taken place in this field of medicine.

Three decades ago the doctor could only deal symptomatically with an acute infection like pneumonia, and realized that he could help the patient but little. This often led to the relatives resorting to quack measures, some of which were far-fetched in the extreme. The practitioner often had to watch helplessly as the patient sank lower and lower, not having one specific curative drug to resort to. Some ray of light for the pneumonic patient filtered through with the drug Transpulmin, a quinine derivative. In the speaker's opinion this was a definite help at times.

Then came chemotherapy and antibiotics, which brought the death-rate for pneumonia down to almost zero. This is one reason why the young practitioner of today has a much easier task than his predecessor of 30 years ago.

It must, however, be remembered not to abuse these drugs—as is often done today—for, in so doing, a race of humans will be

established with very little immunity against organisms usually of low virulence in nature. It leads to a vicious circle, where more and more potent agents will have to be found for humans with less and less resistance and immunity.

With the modern advances in anaesthetic technique, surgery has been simplified tremendously. This can lead to abuse of the knife, and it should be borne in mind that surgery should only be practised when the patient will benefit materially thereby, and for no other reason.

Caesarean section is often overdone. It is sometimes an easy way out for the busy doctor when no true indication for it exists. For this reason the art of midwifery can easily be lost, as well as the infinite patience on the part of the doctor which is so essential in every maternity case.

Dr. van Reenen livened up his address with some highly amusing and interesting anecdotes, and recollected a few experiences which had made a lasting impression on him.

He closed his address with a friendly note of warning to all doctors never to wage war against each other, but instead to take up a united front against man's common enemy—disease.

PASSING EVENTS : IN DIE VERBYGAAN

Mr. Arthur Helfet has returned from a 3 months' visit to Britain and the Continent, during which time he attended the Congress of the International Society of Orthopaedics and the Autumn meetings of the British and French Orthopaedic Associations.

Society for the Study of Fertility. The Society's next Annual Conference will be held at the Medical School, Hospitals Centre, Birmingham, on 23 and 24 June 1955.

Members are reminded that the Association has an arrangement with the Atlas Assurance Company whereby they may insure themselves against claims made by third parties and arising out of their practices.

By agreement with the Federal Council the policy contains special provisions applicable only to members of the Association and which cannot be supplied by any other company.

Enquiries should be addressed to the office of the Association (P.O. Box 643, Cape Town) or to any of the offices of the Atlas Assurance Company.

The Honorary Degree of M.D. will be conferred upon Dr. P. le F. Nortier at the mid-year graduation ceremony at the University of Cape Town in June 1955. Dr. Nortier, who practised at Clanwilliam, is one of the earliest Rhodes scholars of Stellenbosch University. He qualified in medicine at Liverpool University in 1911. In 1952 he was awarded the D.Sc. degree by Stellenbosch University for his researches on the cultivation of rooibos tea and the improvement of the citrus strains of the Citrusdal and Clanwilliam areas.

Mr. B. W. Franklin Bishop, F.R.C.S., late of Kimberley, Cape, who has been working under Prof. T. Pomfret Kilner, C.B.E., F.R.C.S., in the Nuffield Department of Plastic Surgery, Churchill Hospital, Oxford, England, has been appointed assistant to the Professor of Plastic Surgery, Faculty of Medicine, University of Oxford.

Journal of Biophysical and Biochemical Cytology. The Rockefeller Institute for Medical Research announces the publication of a new journal under the above title. Its object will be the presentation of morphological, biochemical and biophysical studies of the structure and functions of cells and their components, with special

attention to cellular organization at colloidal and molecular levels, and emphasis on information derived from newer approaches such as histochemistry, cytogenetics, cytochemistry, electron microscopy and X-ray diffraction. The format and styling will be that of the *Journal of Experimental Medicine* and the *Journal of General Physiology*. Issues will appear bimonthly, commencing in January 1955, and the subscription will be \$7.50 per annum. Editorial office, Rockefeller Institute for Medical Research, New York 21, N.Y.

Leukaemia. The Robert Roesler de Villiers Foundation, Inc., founded to help forward significant discoveries concerning the knowledge and treatment of leukaemia and allied diseases, opened its 'Contest III' on 20 October 1954. A prize of \$5,000 is offered for a preventive measure, cure or control, and \$1,500 or \$1,000 respectively, for a significant contribution of practical or theoretical value. The contest is open to any candidate in any country. Detailed particulars can be obtained from Mr. Rudolph R. de Villiers, Secretary and Treasurer of the Foundation, 1172 Park Avenue, New York 28, N.Y. Papers will be received up to 20 October 1955.

Mr. de Villiers states that in the U.S.A. leukaemia has increased by 72% in the 10 years 1942-52, and that the figures for the Netherlands and Switzerland are similar. The Foundation is planning to provide additional grants and fellowships.

1955 Essay Award Contest of American College of Chest Physicians. The Council on Undergraduate Medical Education of the American College of Chest Physicians offers 3 cash awards to be given annually for the best contribution, prepared by any undergraduate medical student studying for a degree in medicine, on any phase of the diagnosis and treatment of chest diseases (heart and/or lungs.)

The first prize will consist of a cash award of \$250, the second prize \$100 and the third prize \$50, with a certificate of merit.

The contributions will be judged by a committee of chest specialists and the result will be announced at the 21st Annual Meeting of the American College of Chest Physicians, to be held in Atlantic City, New Jersey, 2-5 June 1955. All manuscripts become the property of the College.

Applicants are requested to study the format of *Diseases of the Chest* as to length, form and arrangement of illustrations, to guide them in the preparation of the manuscript. The following conditions must be observed:

1. Five copies of the manuscript, typewritten in English (double

spaced) to be submitted to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois, U.S.A., not later than 10 April 1955.

2. The only means of identification of the author shall be a motto or other device on the title page and a sealed envelope bearing the

name motto on the outside and enclosing the name and address of the author.

3. A letter from the Dean or Chairman of the Department of Medicine of the Medical School certifying that the author is a medical student studying for his degree in medicine.

NEW PREPARATIONS AND APPLIANCES : NUWE PREPARATE EN TOESTELLE

Hepatex Fortified, Evans Medical Supplies announce, is a new preparation for intramuscular injection in the treatment of all macrocytic anaemias. It is a crude proteolysed liver extract, fortified with additional vitamin B12, folic acid, para-amino-benzoic acid and nicotinamide.

Macrocytic anaemias with megaloblastic bone marrow have a widely varying aetiology and distribution, involving in all cases inadequate intake, absorption or utilization of haemopoietic factors, especially vitamin B12 and folic acid. Frequently, however, there is a multiple deficiency and administration of vitamin B12 or folic acid alone will not completely remedy the blood picture. In such cases, crude proteolysed liver extract is also required.

Hepatex Fortified consists of Vitamin B12, 15 mcg.; Folic Acid, 5 mgm.; Nicotinamide, 100 mgm.; Para-amino-benzoic Acid, 2 mgm.; Crude proteolysed liver extract 1 ml.

It thus contains adequate amounts of all the known factors required for normal bone marrow function. In addition to acting as stabilizers for folic acid, which is normally unstable at the pH required by vitamin B12, nicotinamide and para-amino-benzoic acid play an important part in vitamin B group metabolism.

Hepatex Fortified is available in 10 ml. rubber-capped vials. Detailed literature and samples are available from: Evans Medical Supplies, P.O. Box 6607, Johannesburg.

Maybaker (S.A.) (Pty.) Ltd. announce the introduction of two preparations:

Anthical brand lotion presents mepyramine maleate in association with zinc oxide in a stable suspension with a creamy consistency. The lotion combines the analgesic, antihistaminic and anti-pruritic properties of mepyramine with the soothing and mildly astringent properties of zinc oxide. It is intended for topical application in sunburn, prickly heat, insect bites and minor pruritic conditions. It may also be used in more severe pruritus and allergic skin disorders when an antihistamine is indicated in a non-greasy liquid vehicle.

Procardyl brand procainamide is introduced for the control of certain cardiac arrhythmias. Procainamide is similar in action to procaine hydrochloride, but with a more prolonged effect and without central stimulatory action. *Procardyl* is used in anaesthetised patients, to terminate or modify cardiac arrhythmias, and in conscious patients to control ventricular arrhythmias and disturbances of auricular rhythm such as ectopic beats, tachycardia, flutter and fibrillation. The hypotensive action of procainamide has been used to enhance the action of hexamethonium salts in producing and maintaining controlled hypotension in surgery. *Procardyl* is available as a 10% solution.

BOOK REVIEWS : BOEKRESENSIES

FORENSIC MEDICINE

Legal Medicine. Edited by R. B. H. Gradwohl, M.D., Sc.D., F.A.P.H.A., Commander, M.D., U.S.N.R. (Retired). (Pp. 1093+xvii, with 222 illustrations. £5 2s. 0d.) St. Louis: The C.V. Mosby Company. 1954.

Contents: 1. The History and Development of Legal Medicine. 2. Special Aspects and Practical Considerations of the Medicolegal Autopsy. 3. Legal Authorization for Autopsy. 4. Law Relating to Medical Practice: The Doctor's Diagnosis and Treatment of Patients. 5. Forensic Thanatology. 6. Post-Mortem Changes; Vital Reactions; Fat Embolism; Air Embolism. 7. Common Causes of Unexpected Deaths. 8. Effect of High and Low Temperature, Electric Current, and Radiation. 9. Wounds of the Head and Body and their Interpretation. 10. Mechanical Asphyxia. 11. Pathological Findings in Poisonings. 12. Recent Advances in the Treatment of Poisoning. 13. Sudden Deaths in Infants and Children. 14. Septal Pneumonia as a Cause of Infant Death. 15. Forensic Aspects of Trauma to the Central Nervous System and its Membranes. 16. Rape. 17. Evaluation of Evidence from the Skeleton. 18. Dental Evidence in Identification and Criminology. 19. The Examination of Hairs and Fibres. 20. Identification of Blood Stains. 21. Blood Grouping Tests in the Determination of Nonpaternity. 22. Paternity Proceedings and Blood Tests. 23. Examination of Seminal Fluid. 24. Toxicology. 25. Microscopic-Crystallographic Procedures for Identification of Drugs. 26. Medicolegal Aspects of Alcohol Intoxication. 27. Medicolegal Problems of Workmen's Compensation. 28. Pregnancy and Abortion. 29. Infanticide. 30. The Law of Abortion. 31. Forensic Psychiatry. 32. Legal Relations of the Mentally Ill. 33. Narcoanalysis for Criminal Interrogation. 34. Lie Detection. 35. The Expert Witness. 36. The Medical Expert Witness. 37. Police Laboratory Administration. 38. Legal Aspects of Trauma and Disease. 39. Official Medicolegal Investigations. Index.

The field of forensic medicine is ill-defined and ramifies into many of the nooks and crannies of medicine. There are few textbooks or works of reference covering the subject and this latest contribution is welcome.

This book recalls a recent South African publication on the same subject. They both cover forensic pathology and medical law. *Legal Medicine* has the disadvantage of having 29 collaborators. This is its greatest weakness, because it results in lack of correlation between chapters and too great a variability in the

standard of contributions. Certain chapters are good, others poor; and the style varies from scientific reporting to journalese.

There should be no place in a book of this sort for chapters written in essay style. The section offending most in this respect is that on Forensic Psychiatry. On the other hand, the section on alcohol is well presented, with some very clever illustrations. There is a tendency to describe details of laboratory techniques which is more suitable for a laboratory manual than for a book on legal medicine.

Good sections deal with autopsy technique, evaluation of evidence from the skeleton, blood-grouping tests (which appear to be much used as evidence in American Courts owing to the frequency of paternity suits) and forensic dentistry. This last subject is generally not given sufficient attention in medico-legal books. Another topic which does not feature in other books but is found in this book is that on sudden death in infancy and childhood.

Poisoning and toxicology are retained as subjects falling within the scope of forensic medicine and there is certainly place for these chapters, though many today regard them as a separate speciality. One would have liked more medico-legal information about modern toxic insecticides such as parathion.

A noteworthy omission in this volume is the failure to deal with gunshot wounds generally and ballistics. The book is inadequate on sex crimes, while rape is hardly dealt with.

On the legal side American law is quoted. Where this is applied, e.g. in legal authorization for autopsy, it will not help South African doctors. Questions of law relating to medical practice, diagnosis and treatment are, however, based on principles of Anglo-American law and as such are of definite value to doctors in this country. The editor has avoided the pitfall of presenting too much law. There is a sensible chapter on the expert witness. But one can imagine the forthright and vigorous rejection by South African Courts of evidence produced by such bizarre

means as narco-analysis, the 'truth serum' and the lie detector.

An exceptionally good feature is the bibliography provided with each chapter. Though the book is not suitable as a textbook (which presumably it is not meant to be) it is a good work of reference.

* All in all the book covers in an interesting way the field of legal medicine, and every doctor whose duties bring him into the courts should have this publication.

A.P.

TREATMENT OF FRACTURES

Illustrated Review of Fracture Treatment. By Frederick Lee Liebolt, A.B., M.D., Sc.D., LL.D. First Edition. (Pp. 229, with 605 figures. \$4.00). California: Lange Medical Publications. 1954.

Contents: 1. Anatomy and Physiology. 2. Clinical Examination of Fractures. 3. Principles of Treatment of Fractures. 4. Fractures of the Head and Face. 5. Fractures of the Vertebral Column. 6. Fractures of the Thorax. 7. Fractures of the Shoulder. 8. Fractures of the Arm. 9. Fractures of the Elbow. 10. Fractures of the Forearm. 11. Fractures of the Wrist. 12. Fractures of the Hand. 13. Fractures of the Pelvis, Hip and Thigh. 14. Fractures of the Knee. 15. Fractures of the Leg. 16. Fractures of the Ankle. 17. Fractures of the Foot. Glossary. Index.

Here is 'yet another' book on fractures, but one which merits the attention of those for whom it is intended, viz. medical students, house officers and general practitioners. The book is intended to illustrate, and to discuss, briefly and systematically, the principal features concerning the diagnosis and treatment of fractures. The contents are brief and arranged in summary form, and therefore inevitably incomplete in parts.

In 225 pages there are 605 figures, of which the majority are line drawings, the rest being reproductions of roentgenograms. The line drawings are clear and descriptive. A typical chapter starts with drawings of the anatomy of the bones under discussion, followed by vivid examples of direct and indirect trauma to the bones, drawings of typical displacements, roentgenograms of the fractures, and drawings of first-aid treatment, reduction and immobilization.

The text in each chapter is arranged systematically in summary form under the following headings: etiology, incidence, pathology, clinical findings, X-rays, treatment (first-aid, conservative, surgical), complications, time of immobilization and healing, and prognosis.

This is obviously not a book for the specialist. For the medical student, however, it is a good companion. The modern student has to absorb an enormous amount of knowledge in the time available for his clinical training, and if information can be presented to him in the simplest possible manner it makes his task so much the lighter.

A few criticisms must be mentioned. On page 16 it is stated that passive movements of joints should be commenced early, and active movements not instituted until after the union of the fracture. This is surely in direct contrast to current practice.

Generally, simpler methods for treating fractures of the nose are in use than those described on page 25.

In the chapter on fractures of the mandible, extra-oral splintage is not mentioned.

On page 139, complications of rupture of bladder and urethra are not mentioned in the discussion of fractures of the pelvis.

Bearing in mind the above criticisms, then, the book will be useful to students. It is compact, easy to carry, contains illustrations which will vividly impress the points concerned on the students' mind, and has an easily readable text presented in summary form.

R.S.

OTOLARYNGOLOGY

Fundamentals of Otolaryngology. By Lawrence R. Boies, M.D. (Pp. 487+xix, with 197 illustrations.) Philadelphia & London: W. B. Saunders Company. 1954

Contents: Part I. The Ear. 1. Applied Anatomy and Physiology of the Ear. 2. Examination of the Ear. 3. Hearing Loss. 4. Diseases of the External Ear and External Auditory Canal. 5. Acute Middle Ear Disease. 6. Chronic Middle Ear Disease. 7. Complications of Suppurative Otitis Media. 8. Tinnitus. 9. Vertigo. 10. Aids to Hearing-Audiology. Part II. The Nose. 11. Applied Anatomy and Physiology of the Nose. 12. Examination of the Nose. 13. The Common Cold. 14. Nasal Allergy. 15. Chronic Nasal Obstruction. 16. Acute and Chronic Sinus Disease. 17. Complications of Sinusitis. 18. Headache and Neuralgia of Nasal Origin. 19. Epistaxis. 20. Atrophic Rhinitis. 21. Injuries to the Nose. Part III. The Throat. 22. Applied Anatomy and Physiology of the Throat. 23. Examination of the Throat. 24. Diseases of the Nasopharynx. 25. Acute and Chronic Sore Throat. 26. Tonsils and Adenoids. 27. Hoarseness. 28. Laryngeal Obstruction. 29. Dysphagia. 30. Foreign Bodies in the Air and Food Passages. 31. Bronchoscopy and Bronchography in Pulmonary Disease. 32. Tumors of the Nose and Throat. 33. Modern Medication in Otolaryngology. Addendum. Index.

In his introduction, the author of this book states that surveys of rural general practice in Minnesota, U.S.A. have shown that approximately 25% of the activities of the general practitioner are concerned with otolaryngological disorders, and there appears to be no reason to doubt that the same figure would apply to South African practice. Thus one can see the importance to the medical student and practitioner of a sound basic knowledge of this subject, which it must be admitted he does not always possess.

The difficulties of peering into small sensitive cavities such as the ear and nasopharynx can only be overcome by constant practice, but a perusal of this book will go far towards giving the student a good conception of what he is looking at and what abnormalities to look for. Methods of examination and common minor operations are well described both in the text and by clear illustrations.

As the book confines itself to fundamentals only, major operations are merely mentioned and very little controversial matter or discussion is included. However, the reviewer feels that in many cases the treatment of certain disorders, e.g. migraine, could have been dealt with more fully and the specific dosages of drugs given, as the book is also intended to be a reference for general practitioners. Phrases such as 'plenty of preliminary sedation is helpful' are not themselves very helpful.

However, it is pointed out that this book is intended only to impart the fundamentals of the subject, and for this it can be commended. At the end of each chapter there is a list of references, for those who would further extend their knowledge.

W.F.D.C.

CORRESPONDENCE : BRIEWERUBRIEK

SURGICAL TREATMENT OF A CASE OF WRY-NECK

To the Editor: In the article¹ on this subject published in the *Journal* on 30 October you 'touched up' the scar on the neck in order to show where it was supposed to be. This produced an appearance of bad keloid which is in complete variance with the true situation, as part of the objective of the paper was to indicate an approach which left an inconspicuous result.

We would be glad if you would publish this letter to indicate that the scars as shown in the photographic reproduction were a considerable exaggeration of the real state of affairs.

Jack Penn,
Wilfred Kark,

Ingram's Corner
Hillbrow
Johannesburg
18 November 1954

1. Penn, J. and Kark, W. (1954): *S. Afr. Med. J.*, **28**, 929.

STERILIZATION OF WOMEN

To the Editor: It gave me much pleasure to read your correspondent's letter¹ in the *Journal*. Whatever one's views on sterilization may be, here at least was commonsense, humanity and an acceptance of the fact that sex is here to stay.

Some while ago, a 35-year-old woman who had 10 healthy children came to see me about sterilization. I wonder how many of us would be greatly troubled by religion, ethics or the law in advising the procedure if she were our wife. Surely we can leave the State out of this as it is after all a problem for the patient, her husband and the doctor to decide.

D. T. Dodds,

607 Sanlam Building
Port Elizabeth
17 November 1954

1. Laurie, R. D. (1954): *S. Afr. Med. J.*, **28**, 960 (6 November).

MEDICAL COUNCIL ATTITUDE

To the Editor: Drs. Blignaut¹ and Laurie² however excellent their intentions, had better beware or they may be brought up sharply by the Medical Council to give an account of their doings.

Some 2 years ago, at the instigation of the S.A.R. & H. Sick Fund, I was peremptorily requested by the Registrar of the South African Medical and Dental Council to explain a sterilization I had performed on a Railway patient. She, fortunately for me, had 8 good reasons, viz., 4 children and 4 miscarriages in 6 years, and was a virtual invalid as a consequence. I was informed in an equally curt fashion some time later that the Medical Council had decided to take no further steps in the matter. Something like the Scottish verdict 'not proven' I've always felt!

I did nothing further in the matter coming as it did during my other case, but as the instigator of the enquiry I've always felt that the Medical Council should have a clear-cut definition of the position ethically.

Professor Price of Cape Town University states categorically that there is nothing in the Roman Dutch law which forbids a person having himself or herself sterilised as a contraceptive measure. The Medical Council by its action in my case implies it has the ethical right to judge of the rights and wrongs of sterilization.

Where do we stand in the meantime?

K. M. Hairman,

615/618 S.A. Mutual Building
Gardiner Street
Durban
15 November 1954

1. Blignaut, W. (1954): S. Afr. Med. J., 28, 938 (30 October).
2. Laurie, R. D. (1954): *Ibid.*, 28, 960 (6 November).

STERILIZATION AND CONTRACEPTION

To the Editor: The mention by Dr. R. D. Laurie in the *Journal* of 6 November 1954 of religious and moral views in respect of the above has prompted me to add a word or two.

No woman who wishes a child (or more children) wants to be sterilized. Yet many of them are. Peritonitis, adnexal inflammations and hormonal imbalances, among others, do the job.

There are others whom the surgeon assists to the same end—with good medical reasons, either physical or psychical, or both. Fear of further pregnancy in marriage where, for instance, the husband is physically or mentally unable to care for a further addition to the family, can do most unpleasant things to the wife's mental outlook, and thus to the peace within the home. So also when the woman is for some medical reason unfitted for motherhood.

Where these and similar considerations do not apply the question is one of ethics and law more than one of religion and morality.

For instance we read: 'I say unto you, whosoever shall put away his wife, except it be for fornication, and shall marry another, committeth adultery; and whoso marrieth her which is put away doth commit adultery. His disciples say unto Him, If the case of the man be so with his wife, it is not good to marry. But He said unto them, All men cannot receive this saying, save they to whom it is given. For there are some eunuchs, which were so born from their mother's womb: and there are some eunuchs, which were made eunuchs of men: and there be eunuchs, which have made themselves eunuchs for the Kingdom of Heaven's sake. He that is able to receive it, let him receive it.'¹

Then we read also the following: 'To avoid fornication, let every man have his own wife, and let every woman have her own husband. Let the husband render unto the wife due benevolence: and likewise also the wife unto the husband. The wife hath not power of her own body, but the husband: and likewise also the husband hath not power of his own body, but the wife. Defraud ye not one the other, except it be with consent for a time, that ye may give yourselves to fasting and prayer: and come together again, that Satan tempt you not for your incontinency.'²

There is nothing herein that indicates marriage to have the purpose of procreation only, or companionship only. In fact Paul goes on: 'If they cannot contain, let them marry: for it is better to marry than to burn.'³

The sex-sublimation of the bachelor or spinster who have

dedicated their lives to some cause that would be interfered with by marriage must be differentiated from impotency and frigidity. Also, the healthy state in marriage is not one of impotency or frigidity, though sex-sublimation may be called for from time to time, as for instance in time of war when the spouses are parted, when sickness assails one or the other, or when considerations of special work require a separation for a greater or lesser length of time.

The question of sterilization for non-medical reasons is one for the Legislature to decide.

Letter curtailed.

J. J. de Villiers

184 Pine Street
Arcadia
Pretoria
9 November 1954

1. Matth. 19: 9—12.
2. I Cor. 7: 2—5.
3. I Cor. 7: 9

THE NON-EUROPEAN MEDICAL SCHOOL

To the Editor: A fully established school for non-Europeans in South Africa is now a living reality, and while one rejoices that it is so, one feels that the present is a suitable occasion for reminding the European and the non-European public of South Africa of the public-spirited group of men who were responsible for the propagation of the idea. I refer to Dr. C. T. Loram, of the Native Affairs Commission, Dr. W. Darley-Hartley, of Cape Town, Professor R. A. Dart, of the University of the Witwatersrand, Dr. W. A. Murray, of the Union Health Department, Dr. J. C. Pretorius, of Bloemfontein, and Mr. W. G. R. Murray, of the University of Cape Town.

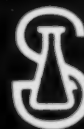
These gentlemen were members of the Committee which had been appointed by the Union Government 'to enquire into the training of Natives in medicine and public health'. This Committee presented its historic report to both Houses of Parliament by command of His Excellency the Governor-General in February 1928. In their deliberations the Committee were ably assisted by a number of medical witnesses which included Dr. W. T. Davies, Dr. A. J. Orenstein, Dr. J. M. De Wet, Dr. A. J. Milne, Prof. G. Gordon Grant, Dr. A. H. Watt, Dr. I. W. Brebner, Dr. M. S. Molema, Dr. D. G. Ritchie Thomson, Dr. W. Girdwood, Prof. J. M. Watt, Dr. M. J. A. Des Ligneris, Dr. A. I. Girdwood, Prof. A. W. Falconer, Prof. M. R. Drennan, Prof. W. A. Jolly, Dr. A. W. Simpson Wells, Dr. J. B. McCord, Dr. D. Campbell Watt, Dr. G. A. Park Ross, Dr. A. B. Taylor, Dr. S. J. Clegg, Dr. A. G. Stewart, Dr. J. S. Moroko, Dr. L. W. Barlow, Dr. W. MacVicar, Dr. D. Miller, Dr. G. O. Doran, Dr. J. Handerson, Dr. P. Ganteaume, Dr. E. Hill, Dr. A. M. Craib, Dr. P. W. Laidler, Dr. W. B. Rubasana, Dr. C. P. Blight Wall, and Dr. R. N. Pringle.

The Committee, after due deliberation, recommended *inter alia* that facilities be established for the medical training of non-Europeans in South Africa, and, in making their recommendations, they fully appreciated that the growing intensification of the processes of industrialization and urbanization would make such a step as sociologically inevitable as it was morally desirable. The Committee recognized, for example, that 'the health of the people was a matter of national concern', that 'sickness meant loss of national efficiency', and that, accordingly, 'society had to awake to a sense of corporate responsibility for its preservation'.

The dream of the members of the Committee has now been realized. The non-European Medical School, now firmly established in Durban under the aegis of the University of Natal, is destined to become a stabilizing force in South African life, and a solemn earnest of European goodwill. In so far as this is so, it is not fitting that the members of the Committee be remembered, and the surviving members honoured, at the present juncture? In making the suggestion that this be done by the University of Natal, I feel that I am giving expression to the consensus of public opinion in this great country.

Louis F. Freed

2 Barbican Buildings
President Street
Johannesburg
30 October 1954

**ORETON-M**

NOW

Methyltestosterone *in two oral forms*



ORETON-M

(Chemically identical with TESTOVIRON Brand)

Buccal Tablets,

a new buccal preparation, have been added to our buccal hormone series. Methyltestosterone dissolved in the solid solvent base, POLYHYDROL, assures complete absorption for maximal androgenic effect. Tablets of 10 mg. bottles of 30 and 100.



ORETON-M

(Chemically identical with TESTOVIRON Brand)

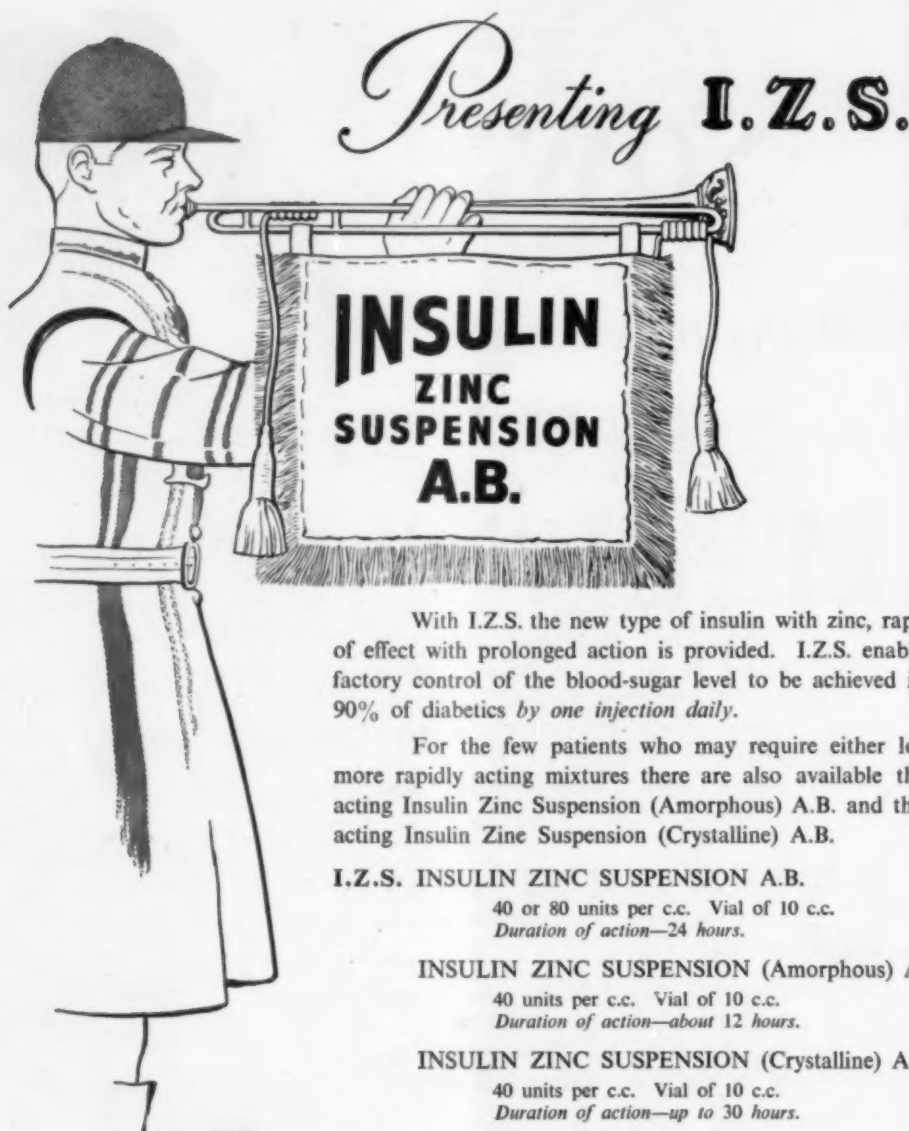
Tablets,

as previously available, permit wide flexibility of dosage utilizing the conventional oral route. Tablets of 10 mg., 25 mg. and 50 mg., bottles of 20 and 100.

MANUFACTURED IN THE UNION OF SOUTH AFRICA BY
SCHERAG (PTY.) LIMITED, JOHANNESBURG
FOR AND UNDER THE FORMULA AND TECHNICAL SUPERVISION OF

Schering CORPORATION • BLOOMFIELD, N.J.





With I.Z.S. the new type of insulin with zinc, rapid onset of effect with prolonged action is provided. I.Z.S. enables satisfactory control of the blood-sugar level to be achieved in about 90% of diabetics *by one injection daily*.

For the few patients who may require either longer or more rapidly acting mixtures there are also available the quick acting Insulin Zinc Suspension (Amorphous) A.B. and the longer acting Insulin Zinc Suspension (Crystalline) A.B.

I.Z.S. INSULIN ZINC SUSPENSION A.B.

40 or 80 units per c.c. Vial of 10 c.c.
Duration of action—24 hours.

INSULIN ZINC SUSPENSION (Amorphous) A.B.

40 units per c.c. Vial of 10 c.c.
Duration of action—about 12 hours.

INSULIN ZINC SUSPENSION (Crystalline) A.B.

40 units per c.c. Vial of 10 c.c.
Duration of action—up to 30 hours.



The New **A.B. Insulins**

Joint Licensees and Manufacturers :
ALLEN & HANBURYS LTD., LONDON. THE BRITISH DRUG HOUSES LTD., LONDON.

ALLEN & HANBURYS (AFRICA) LTD.
(Incorporated in England)
121, Congella Road, DURBAN.

Distributors :

BRITISH DRUG HOUSES
(SOUTH AFRICA) (PTY.) LTD.
123, Jeppe Street JOHANNESBURG.

Please Support Our Advertisers — Ondersteun Asseblief Ons Adverteerders



TODAY

the diabetic is anonymous..

Most diabetics today can take their place in normal life. The three 'Wellcome' brand Insulins now available ensure a means of effective treatment over a wide range of individual cases. Unmodified Insulin gives rapid action, while Protamine Zinc Insulin and Globin Insulin represent two differing degrees of slower but more prolonged action. The 'Wellcome' label is the physician's assurance of dependability.

3 'Wellcome' Insulins

INSULIN (Unmodified) • PROTAMINE ZINC INSULIN

GLOBIN INSULIN (with Zinc)



BURROUGHS WELLCOME & CO. (THE WELLCOME FOUNDATION LTD.) LONDON
DEPOT FOR SOUTH AFRICA:
BURROUGHS WELLCOME & CO. (SOUTH AFRICA) LTD., 5, Loop Street, CAPE TOWN



VERACOLATE The true cholagogue-choleretic for Bile Salts therapy...

*TRADE MARK REGD.

Veracolate*, which acts as a physiological choleretic and cholagogue in restoring the secretion of bile to normal, is a highly effective product for the treatment of hepatobiliary disorders. The cholagogic effect is produced by the bile salts Sodium Taurocholate and Sodium Glycocholate; the increased flow of bile has a valuable flushing effect in the gall-bladder and ducts, and the laxative properties of Veracolate promote peristaltic stimulation and ensure evacuation.

Available in bottles of 50 and 100 tablets.

INDICATIONS. Functional insufficiency of the liver. Infections of the biliary tract. Obstructive jaundice. Biliary drainage (non-surgical). During and after pregnancy. Hypoproteinaemia. Habitual constipation. For prophylaxis where gall-stone diathesis exists.

NO WARNER PREPARATION HAS EVER BEEN ADVERTISED TO THE PUBLIC



WM. R. WARNER & COMPANY (PTY) LTD., 6-10 Searle Street, Capetown.

Ergoapiol - (Smith)

A Menstrual Regulator...

When the periods are irregular, due to constitutional causes, ERGOAPIOL (Smith) is a reliable prescription. Containing apiol (M.H.S. special) together with ergot and oil of savin of the highest quality, this preparation effectively stimulates uterine tone and controls menstrual and postpartum bleeding.

In cases of Amenorrhea, Dysmenorrhea, Menorrhagia and Metrorrhagia, Ergoapiol serves

as a good uterine tonic and hemostatic. Valuable in obstetrics after delivery of the child.

DOSAGE: 1 to 2 capsules 3 or 4 times daily. Supplied only in packages of 20 capsules. Literature on request.

As a safeguard against imposition the letters MHS are embossed on the inner surface of each capsule, visible only when the capsule is cut in half at seam as shown.



MARTIN H. SMITH COMPANY
NEW YORK, N.Y.

NAUSEA AND VOMITING IN PREGNANCY



* **HEXADOXIN TABLETS**
continue to be the treatment of choice

DOSAGE: Two tablets three times daily for first day,
then one tablet three times daily for four to five days.

* (Sugar-coated tablets containing Pyridoxine 20 mg., Phenobarb gr. $\frac{1}{2}$)

A SOUTH AFRICAN PRODUCT MADE BY

SAPHAR LABORATORIES LTD.

P.O. Box 256, JOHANNESBURG P.O. BOX 568, CAPE TOWN P.O. BOX 2383, DURBAN P.O. BOX 789, PORT ELIZABETH

The Physician's answer to FAMILY S-P-A-C-I-N-G



Literature available on request from: VULCO CHEMICAL CO. LTD., Box
3754, Johannesburg

**A VERY
MORBID**

ANATOMY..



**the most modern
art of medicine...**

B-COMPLEX THERAPY

Where B-Complex therapy is indicated, there is a PETERVITE product to meet individual requirements or preference.

PETERVITE B TABLETS

Each chocolate-coated tablet contains:

Thiamine Hydrochloride 2.0 mgm.
Riboflavin 1.3 mgm.
Pyridoxine Hydrochloride 0.25 mgm.
Calcium Pantothenate 2.5 mgm.
Nicotinamide 20.0 mgm.
Vitamin B₁₂ (Cyanocobalamin) 1.0 mcgm.
Bottles of 20, 40 and 100.

PETERVITE ELIXIR

Each fluid ounce of orange flavoured wine base contains:

Thiamine Hydrochloride 20 mgm.
Riboflavin 8 mgm.
Pyridoxine Hydrochloride 2 mgm.
Calcium Pantothenate 10 mgm.
Nicotinamide 80 mgm.
Vitamin B₁₂ (Cyanocobalamin) 10 mcgm.
Bottles of 8 oz. and 80 oz.

PETERVITE COMPOUND INJECTION

Each 2 c.c. ampoule contains:

Thiamine Hydrochloride 10 mgm.
Riboflavin 2 mgm.
Pyridoxine Hydrochloride 5 mgm.
Calcium Pantothenate 5 mgm.
Nicotinamide 100 mgm.
Boxes of 6 x 2 c.c. ampoules.

Manufactured in South Africa by



Established 1842

P.O. Box 38
CAPE TOWN

113, Umbilo Road
DURBAN

P.O. Box 2238
SALISBURY

P.O. Box 5785
JOHANNESBURG

P.33.

Money Matters...

The conduct of your personal and business monetary affairs is a matter requiring meticulous attention. A banking account with the Standard Bank is an assurance that your financial transactions are handled safely and conveniently.



The Standard Bank provides a full range of services based on a wide experience of modern banking needs—these are available through over 600 offices throughout South and East Africa.

THE STANDARD BANK

OF SOUTH AFRICA, LIMITED

Registered as a Commercial Bank

ESTABLISHED 1862

HB

VALUABLE BOOK FREE!

ARE YOU PREPARING FOR ANY MEDICAL,
SURGICAL, or DENTAL EXAMINATION?
Send Coupon below for our valuable publication

"GUIDE TO MEDICAL EXAMINATIONS"

PRINCIPAL CONTENTS

The Examinations of the Conjoint Board.
The M.B. and M.D. Degrees of all British Universities.
How to pass the F.R.C.S. Exam.
The M.S. Lond. and other Higher Surgical Examinations
The M.R.C.P. London.
The D.P.H. and how to obtain it.
The Diploma in Anaesthetics.
The Diploma in Psychological Medicine.
The Diploma in Ophthalmology.
The Diploma in Laryngology.
Diploma in Radiology.
The D.R.C.O.G. and M.B.C.O.G.
The Diploma in Child Health.
Coaching also for all South African Medical Examinations.
Do not fail to get a copy of this Book before commencing preparation for any Examination. It contains a large amount of valuable information. Dental Exams. in special Dental Guide.

SEND FOR YOUR COPY NOW!

The Secretary,
MEDICAL CORRESPONDENCE COLLEGE
19 Welbeck Street, Cavendish Square, London W.1.
Sir,—Please send me a copy of your "Guide to Medical Examinations" by return.

Name.....

Address.....

Examination in which interested }.....



I've heard it said that
more wear takes place in an engine
when you stop and start
than when you run for long periods.
That's why I use
SHELL X-100 MOTOR OIL.
It has special additives and forms
a tough resilient film
which clings to all metal surfaces.

SHELL X-100 MOTOR OIL

Virol

FOR INFANTS, CHILDREN
AND INVALIDS

VIROL is a concentrated and scientifically blended supplementary food of high nutritional value; it is designed to provide, in just the right proportions, those specific nutrients most likely to be needed to balance the rest of the diet.

VIROL contains : malt extract ; refined beef fat ; maltose ; cane sugar ; malto-dextrins ; glucose ; fructose ; egg ; orange juice ; salt ; flavourings ; phosphoric acid ; calcium phosphate ; iron phosphate ; sodium iodide ; and vitamins as follows:—

Vitamin A, 1500 i.u. ; Vitamin B₁, 0.4 mg. ;
Nicotinic Acid, 4.5 mg. ; Vitamin D, 1000 i.u. ;
also Iodine, 75 micro-g. ; Iron 8 mg. ; all per ounce.

VIROL is the food for building up strength and vitality—so essential after illness or operation.

Municipality of Randfontein

NOTICE NO. 107 OF 1954

VACANCY : PART-TIME MEDICAL OFFICER OF HEALTH
Applications are hereby invited from qualified Medical Practitioners for the position of Part-time Medical Officer of Health.

Detailed particulars of the conditions and requirements attached to the post can be obtained from the undersigned.

Applications should be submitted on the Council's prescribed form which can be obtained from the undersigned and should reach the Town Clerk, Municipal Offices, Randfontein, not later than 12 noon on Friday 31 December 1954.

Canvassing for appointment in the gift of the Council is strictly prohibited and any proof thereof will disqualify a candidate.

Municipal Offices
Randfontein
18 November 1954

F. A. Meltzer
Town Clerk

D. C no. 4181

Munisipaliteit, Randfontein

KENNISGEWING NR. 107 VAN 1954
VAKATURE : DEELTYDSE MEDIESE
GESONDHEIDSBEAAMPTE

Aansoeke word hiermee ingewag van gekwalifiseerde Mediese Praktisyne om die betrekking van Deeltydse Mediese Gesondheids-beaampte.

Volledige besonderhede van die diensvoorwaardes en vereistes aan die pos verbonde, is van die ondergetekende verkrygbaar.

Aansoeke moet op die Raad se amptelike aansoekvorm wat van die ondergetekende verkry kan word, ingedien word en moet die Stadsklerk, Munisipale Kantoor, Randfontein, uiterlik op 12-uur middag op Vrydag 31 Desember 1954, bereik.

Gunsverwing om aanstelling in die diens van die Raad is streng verbode en enige bewys daarvan sal 'n applikant diskwalifiseer.

Munisipale Kantore
Randfontein
18 November 1954

F. A. Meltzer
Stadsklerk

D. C no. 4181

The Medical Association of South Africa Die Mediese Vereniging van Suid-Afrika

AGENCY DEPARTMENT : AGENTS-KAP-AFDELING

DURBAN

112 Medical Centre, Field Street. Telephone 2-4049

PRACTICES FOR SALE

(PD28) Durban. General practice, also non-European surgery. Owing to ill-health owner wishes to sell as soon as possible. Premium £1,750. House for sale £8,000.

(PD30) Durban. Old-established good class, mainly European practice. Premium £3,000. Owner intends specializing.

(PD31) Natal Inland. Unopposed prescribing practice, mainly Native. Monthly cash receipts average £450. Premium required £2,500 includes surgery, furniture and instruments. House for sale. All sporting facilities.

(PD32) Northern Natal. Well established general mixed practice of 20 years standing. M.O.H. and D.S. appointments. All hospital facilities. Premium £1,500 including surgery furniture and drugs. House £12 per month. For immediate sale.

Physician Specialist unopposed Practice for immediate sale. Inland City Premium £2,500 includes £1,000 equipment.

LOCUMS REQUIRED

(SV5) Locum for January. £3 3s. per day plus board and lodging. £10 car allowance and petrol. Natal Hospital town. Travelling allowance to and from practice for reasonable distance.

(LD6) Natal. From 8 to 23 January 1955. Mainly non-European dispensing with mine Hospital appointment. Own car necessary. £3 3s. per day, all found.

ASSISTANT REQUIRED

(NC5) Assistant required in general practice, country practice. 75% non-European. No surgery or midwifery undertaken. Very little night work. Commence December 1954. Salary £1,200 p.a. ½-hour drive from Durban.

JOHANNESBURG

Medical House, 5 Esselen Street. Telephones: 44-9134, 44-0817
Mediese Huis, Esselenstraat 5. Telefoon: 44-9134, 44-0817
Tel. Add.: 'Serpent'

ASSISTANTS/LOCUMS REQUIRED ASSISTENTE/PLAASVERVANGERS BENODIG

(708) Southern Rhodesia. A locum is required for a large general practice, as from second week in April 1955, for one month. Preferably man who would consider staying on as an assistant with view to partnership. Salary £100 p.m. plus all found. A car is not essential.

(706) Wes-Transvaal. 'n Assistent is benodig vanaf 2 Januarie 1955. Salaris £100 p.m. plus vry petrol en olie en diens van kar plus £10 p.m. kartoelae.

(705) An assistant is required for a large partnership practice in the Free State. Excellent terms to be arranged. 120 miles from Johannesburg.

(704) Near Johannesburg. A locum is required for 3 months, as from 1 December or later. Large partnership practice. £3 3s. Od. per day, plus all found, plus a car allowance.

(699) Locum is required as from 12 December for 1 month. Will suit a newly qualified man. £3 3s. Od. per day, plus all found. Twelve miles from Johannesburg.

(692) Large hospital town, within easy reach of Johannesburg. Locum as from 12 December for 1 month. Partnership practice. £3 3s. Od. per day plus all found and a car allowance.

(690) Groot Transvaalse dorp. Plaasvervanger vanaf 18 Desember tot 18 Januarie. £3 3s. Od. per dag, plus alles vry. Aangename pos.

(689) Transvaal—vennootskap praktyk—100 myl vanaf Pretoria Plaasvervanger vir Desember en Januarie in hierdie vennootskap praktyk, en volgens keuse een maand op dorpie 18 myl daarvandaan. Salaris £90 p.m. vry losies, petrol en olie en £5 per 1,000 kartoelae.

(666) Vrystaat. Plaasvervanger vir een maand vanaf 15 Desember. Terme, £3 3s. Od. per dag, vry losies, petrol en olie en 'n kartoelae van £10 per 1,000 myl.

(652) Large hospital town close to Johannesburg. A Locum is required as from 10 December for one month. Salary £3 3s. Od. per day, plus all found and a car allowance. Native practice. Practically no night work.

(627) O.F.S. Locum required as from 10 December for one month. Salary £3 per day, plus all found. Car could be provided.

(640) O.F.S. Goldfields. Locum is required for December and January. £3 3s. Od. per day, plus free board and lodging, petrol and oil. Partnership practice.

(688) Reef hospital town. Locum for one month as from 13 December. Salary £3 3s. Od. per day plus all found. A car could be provided. Partnership practice.

PART-TIME WORK REQUIRED

Johannesburg. Part-time work or assistantship required, by an experienced doctor. Mornings only.

* * *

KAAPSTAD : CAPE TOWN

Posbus 643, Telefoon 2-6177 : P.O. Box 643, Telephone 2-6177
Waalstraat 35 : 35 Wale Street

PRAKTYKE TE KOOP : PRACTICES FOR SALE

(1759) Westelike Provinsie. Praktyk sonder opposisie. D.S. Aanstelling. Gemiddelde inkomste £3,078. Koopprys £1,500 vir klandisiewaarde, geneesmiddels, instrumente en ameublement. Moderne huis te koop of te huur teen £10 p.m. Betaling kan deur paaiemente geskied.

(1760) Cape Town Suburb. Average annual cash takings £3,442. Scope for surgery, premium £1,750. Payment on terms to be arranged.

(1776) W.P. Hospitaaldorp. Kans vir snykunde. Huis met spreekkamers te koop of te huur. Volle besonderhede op aanvraag.

(1771) Groot plattelandse hospitaaldorp. Eenmanspraktyk. Koopprys £1,000 vir klandisiewaarde, geneesmiddels, instrumente en apteekameublement. Gerieflike moderne huis te koop teen £4,500. Betaling kan in paaiemente geskied.

(1716) Cape Province. Town with Provincial hospital. Gross receipts, 1953/54, £6,900/£6,400. D.S. appointment. House for sale or to let. £3,000 required for goodwill. Payment ± £1,000 cash, balance over 3 years.

OPHTHALMIC PRACTICE FOR SALE

(1325) Excellent practice with two appointments.

ASSISTENTE/PLAASVERVANGERS VERLANG ASSISTANTS/LOCUMS REQUIRED

Locums and/or Assistants are urgently required for urban and rural areas. Details on application.

CONSULTING ROOMS AVAILABLE

(1422) (1579) (1694) in Cape Town. Available on temporary or permanent basis. Full use or to share.

SPECIALIST PHYSICIAN

Specialist practice offered for sale. Details on application.

PART-TIME MEDICAL OFFICER—DURBAN TRANSPORT MANAGEMENT BOARD

Applications are invited from registered Medical Practitioners for the post of part-time Medical Officer to the Durban Transport Management Board.

The successful candidate will be required to undertake the periodical medical examinations of Transport Drivers employed by the Transport undertaking. Such examinations will be carried out on a weekly sessional basis lasting for two to three hours at the consulting rooms of the part-time Medical Officer appointed who will be expected to provide the necessary equipment for such examinations.

Remuneration will be at the rate of £2 2s. Od. per hour or part thereof. The appointment will be subject to 30 days notice on either side.

Applications stating age, qualifications etc., should be forwarded so as to reach the General Manager, Transport Department, Alice Street, Durban, not later than Saturday 18 December 1954.

Provinsiale Administrasie van die Kaap die Goeie Hoop

UNIVERSITEIT VAN KAAPSTAD: GESAMENTLIKE
MEDIESE PERSONEEL VIR GROOTE SCHUUR EN ANDER
OPLEIDINGSHOSPITALE: VAKATURE

1. Aansoeke word ingewag van geregistreerde geneesheer (geregistreerde spesialiste) vir aanstelling tot die volgende pos:
Departement van Kindersiektes:

1 pos van Geneesheer, Graad D, met salaris volgens die skaal £1,200x50—1,500 per jaar.

2. Die diensvoorwaardes word voorgeskryf ingevolge die Ordonnansie op Hospitaalraadsdiens no. 19 van 1941, soos gewysig, en die regulasies wat daarkragtens opgestel is.

3. Benewens die salarisskaal soos aangedui is 'n lewenskoste-toelae teen bedrae wat van tyd tot tyd deur die Administrateur vasgestel word aan voltydse beamptes en werknemers betaalbaar.

4. Van die Gesamentlike Mediese Personeel word vereis om die Provinsiale Administrasie van die Kaap die Goeie Hoop en die Universiteit van Kaapstad gesamentlik te dien.

5. Kandidate moet geregistreerde spesialiste wees in die spesialiteit waarin die vakature bestaan.

6. Aansoek moet gedoen word op die voorgeskrewe vorm (Staf 23), wat verkrygbaar is by die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, of by die Mediese Superintendent van enige Provinsiale hospitaal of by die Sekretaris van enige skoolraad in die Kaapprovinsie.

7. Die ingevulde aansoekvorms moet aan die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, gerig word en moet hom uiters op 18 Desember 1954 bereik. 129335

City of Johannesburg

VACANCY FOR PHYSICIAN-IN-CHARGE : FEVER HOSPITAL

Applications are invited for the position of part-time Physician-in-Charge at a salary at the rate of £912 per annum.

Applicants must be registered Specialist Physicians who have had experience of Fever Hospital administration and the treatment, medical and surgical, of infectious diseases in recognized isolation hospitals.

The successful applicant will be required to attend the Council's Fever Hospital at such times and perform such duties as may be allocated from time to time by the Medical Officer of Health. He will also act as consultant in individual cases at Waterval Hospital or elsewhere when so required.

Personal canvassing for appointment in the gift of the Council is strictly prohibited; proof thereof shall disqualify candidates for appointment.

Full particulars of the duties and conditions of service, and the special application form, may be obtained on application to the Medical Officer of Health, 18 Hoek Street (or P.O. Box 1477), Johannesburg. Applications for the position must be forwarded to the Medical Officer of Health within 14 days of the date of publication of this advertisement.

Brian Porter
Town Clerk
2808/1998

Moroka Methodist Mission Hospital Thaba 'Nchu, O.F.S.

Applications are invited for the post of Interne. The post is particularly suitable for someone interested in Surgery.

Emoluments at the rate of £300 per annum (including cost of living allowance), plus board, lodging and laundry.

The hospital is situated 40 miles east of Bloemfontein, has 120 beds, an X-ray and two well equipped operating theatres. Applicants must be in sympathy with the Christian Witness of the Mission and willing to assist in the training of student nurses. We are recognized as a first class training school for nurses.

For further particulars apply Medical Superintendent.

Medical Officer

Applications are invited from Registered Medical Practitioners for the post of Railway Medical Officer on the Construction Works, Bannockburn/Pafuri Extension from 1 January 1955 or as soon thereafter as possible. (Bannockburn is some 15 miles from Shabani and Pafuri is on the Southern Rhodesia-Portuguese East Africa border.)

Salary: £1,800 per annum (inclusive of all allowances). Motor transport provided. Free unfurnished field quarters provided.

The duties will consist of providing medical attention to Railway employees and their dependants (European and African) and to the employees of Railway Contractors, and their dependants, engaged on construction work. Also supervision of hygiene. The appointment is a temporary post for a minimum period of nine months with a possible extension. Further information will be supplied to suitable applicants.

Applications, stating age, qualifications, previous experience, birth place, civil status, nationality, copies of recent testimonials and stating earliest date possible for commencement of duties, should be forwarded immediately to: The Chief Medical Officer, Rhodesia Railways, P.O. Box 792, Bulawayo.

M.D.117

Local Health Commission

VACANCY FOR ASSISTANT MEDICAL OFFICER OF HEALTH

Applications are invited from registered Medical Practitioners possessing a recognised Diploma in Public Health or State Medicine to fill the above permanent pensionable position on the salary grade £1,130x50—1,280 per annum plus cost-of-living allowance, which is at present £234 per annum for married officials.

Further particulars and official application forms are obtainable from the undersigned.

The appointment and commencing salary are subject to the prior approval of the Minister for Health.

Applications in sealed envelopes endorsed "Application for Assistant Medical Officer of Health" will be received by the Secretary until noon on Friday 17 December 1954.

D. R. Donaldson
Secretary

Local Health Commission Offices
195 Longmarket Street
Pietermaritzburg
15 November 1954

1491

Basutoland Government

VACANCIES FOR MEDICAL OFFICER OF SCHOOLS AND HEALTH

Applications are invited from registered Medical Practitioners for the above pensionable post on the salary scale £865 : £865 : 935x35—1,005x45—1,140x45—1,320. Cost of Living Allowance is payable; the present rates are:

Married Officers on the first £800 of salary, 19%: on the remaining salary, 14%. Maximum allowance £212 per annum. Single Officers, one-half of the above rates, subject to a maximum of £106 per annum.

Rental deduction of 10% of salary for furnished quarters.

Increments will be given on first appointment for war service and approved professional experience, and additional increments will be given to a successful candidate holding a Diploma in Public Health.

An allowance of £150 per annum in lieu of private practice will be granted.

Subject to the exigencies of the service six weeks' accumulative vacation leave and two weeks' non-accumulative occasional leave is granted each year. Overseas' leave passage allowance for officer, wife and proportionate allowance for children every three years.

Further particulars and forms of application may be obtained from the Director of Medical Services, Maseru, Basutoland.

2535/54

Natal Provincial Administration

VACANCIES: REGISTRARS AT GREY'S, EDENDALE, ESHOWE, EMPANGENI, VRYHEID AND NEWCASTLE HOSPITALS

Applications are invited from Registered Medical Practitioners for appointment to the posts of Registrar at the following hospitals:

Grey's—(General Duties).

Edendale Non-European—(Outpatient Department, Anaesthetics).

Eshowe—(General Duties).

Empangeni—(General Duties).

Vryheid—(General Duties).

Newcastle—(General Duties).

Salary is on the scale £720—£840×60—£1,020: 'and the commencing salary payable will be determined on the basis of one notch on the relative scale for each completed year's appropriate experience, after the completion of the qualifying period of two years'.

Cost of Living Allowance is also payable at the following rates:

Married (Male) £320 per annum.

Single (Male and Female) £100 per annum.

The posts are not pensionable at present but may be made pensionable during the course of the next year.

Applications for the posts must be made on Form Z.83, which is obtainable from any Provincial or Government Office, and must be forwarded with full particulars of previous experience, to the Director of Provincial Medical and Health Services, P.O. Box 20, Pietermaritzburg.

AD8479

Natalse Provinsiale Administrasie

VAKATURES: ADJUNK-ASSISTENTGENEESHERE TE GREYSHOSPITAAL, DIE HOSPITAAL VIR NIE-BLANKES TE EDENDALE, EN DIE HOSPITAAL TE ESHOWE, EMPANGENI, VRYHEID EN NEWCASTLE

Aansoeke om aanstelling in die betrekking van Adjunk-assistent-geneesheer aan die ondergenoemde hospitale word van geregistreerde mediese praktisyns ingewag.

Greyshospitaal—Algemene pligte.

Hospitaal vir nie-blankes, Edendale (buitepasientafdeling, narkotisering).

Hospitaal te Eshowe—Algemene pligte.

Hospitaal te Empangeni—Algemene pligte.

Hospitaal te Vryheid—Algemene pligte.

Hospitaal te Newcastle—Algemene pligte.

Salaries is volgens die skaal £720—£840×60—£1,020: 'en die aanvangssalaris sal bepaal word of grondslag van een kerf of die betrokke skaal vir elke volle jaar gepaste ondervinding na voltooiing van die voorbereidingsdiens van twee jaar.

Duurtetoeslag teen onderstaande tariewe is ook betaalbaar:

Getroudes (Mans): £320 per jaar.

Ongetroudes (Mans) of (Vroue): £100 per jaar.

Die poste is op die oomblik nie pensioengewend nie maar dit mag in die loop van die volgende jaar pensioengewend gemaak word.

Aansoeke om die betrekking moet gedoen word op die voorgeskrewe vorm Z.83, wat verkrygbaar is by enige provinsiale of goewernmentskantoor, en moet tesame met volledige besonderhede van vorige ondervinding, gerig word aan die Direkteur van Provinsiale Mediese en Gesondheidsdienste, Posbus 20, Pietermaritzburg.

AD8479

VENNOOT BENODIG

Vennootskappraktyk in baie groot vooruitstrewende hospitaaldorp in N.-Transvaal. Vennoot tree uit 1 April 1955. Inkomste baie goed. Alleenlik privaat praktyk onderneem. Algemene Praktisyn met ondervinding in algemene praktyk en ook belangstelling in snykunde verlang. Doen aansoek A.X.C., Posbus 643, Kaapstad.

PRACTICE OR PARTNERSHIP REQUIRED

Experienced practitioner requires practice or partnership. Higher qualifications and overseas post graduate experience. Mainly interested in Paediatrics. Rhodesia considered. Apply A.W.W., P.O. Box 643, Cape Town.

Provinsiale Administrasie van die Kaap die Goeie Hoop

VICTORIA-HOSPITAAL, LOVEDALE

VAKATURE: MEDIESE GENEESHEER GRAAD 'A'

(Salarisskaal £500—£600—£660—£720)

Aansoeke word ingewag van persone met geskikte kwalifikasies vir aanstelling tot die bogenoemde pos.

Benewens die salarisskaal soos aangedui is 'n lewenskostetoelae betaalbaar aan volttydse beaampte en werknemers teen bedrae wat van tyd tot tyd deur die Administrateur vasgestel word. Die huidige tarief is £110 per jaar vir ongetroude persone en £352 per jaar vir getroude mans.

Die diensvoorwaardes word voorgeskryf ingevolge die Ordonnansie op Hospitaalraadsdiens nr. 19 van 1941, soos gewysig, en die regulasies daarkragtens opgestel.

Die aanstelling sal, in die eerste opsig, onder kontrak vir twaalf maande wees.

Aansoek moet gedoen word, in duplo, op die voorgeskrewe vorm (Staf 23) wat verkrygbaar is by die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, of by die Mediese Superintendent van enige provinsiale hospitaal of by die Sekretaris van enige skoolraad in die Kaapprovinsie.

Die voltooië aansoekvorms moet gerig word aan die Mediese Superintendent, Victoria-Hospitaal, Lovedale, K.P.

Kandidate moet die vroegste datum meld waarop hulle diens kan aanvaar.

179647

Provincial Administration of the Cape of Good Hope

VICTORIA HOSPITAL, LOVEDALE

VACANCY: MEDICAL PRACTITIONER GRADE 'A'

(Salary Scale £500—£600—£660—£720)

Applications are invited from suitably qualified persons for appointment to the above post.

In addition to the salary scale indicated a temporary cost of living allowance, at rates prescribed from time to time by the Administrator, is payable. The present rate is £110 per annum for single persons and £352 per annum for married men.

The conditions of service are prescribed in terms of the Hospital Board Service Ordinance No. 19 of 1941, as amended, from time to time, and the regulations framed thereunder.

The appointment will be on contract for twelve months in the first instance.

Applications should be submitted, in duplicate, on the prescribed form (Staff 23) which is obtainable from the Director of Hospital Services, P.O. Box 2060, Cape Town, or the Medical Superintendent of any provincial hospital or Secretary of any School Board in the Cape Province.

The completed application forms should be addressed to the Medical Superintendent, Victoria Hospital, Lovedale, C.P.

Candidates should state the earliest date on which they will be able to assume duty.

M179647

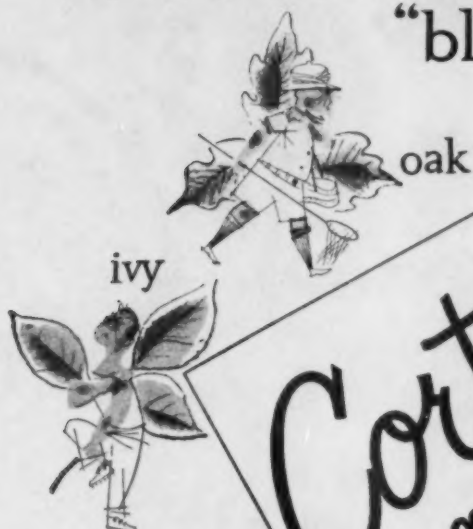
DURBAN MEDICAL PRACTITIONER

Assistant urgently required; to commence as soon as possible. Own car essential. £100 per month plus car allowance. Good prospects, especially if applicant has a working knowledge of Native practice. Write A.X.D., P.O. Box 643, Cape Town.

LOCUM REQUIRED

Robertson. Locum required from 15 December for 1 month. One partner away at a time. General practice with D.S. Salary £3 3s. 0d. per day, plus board and lodging and car allowance. Car could be provided if necessary. Apply A.X.E., P.O. Box 643, Cape Town.

for the flora that
"bloom" in the spring



Cortril
acetate
topical
ointment

provides the proven
advantages of
hydrocortisone for topical
anti-inflammatory therapy of
rhus dermatitis
without systemic effect

Cortril
brand of hydrocortisone
acetate topical ointment

in 1/6-ounce tubes, in two strengths: 1.0% (10 mg. per Gm.) 2.5% (25 mg. per Gm.)

other CORTRIL dosage forms:

CORTRIL Acetate Aqueous Suspension for intra-articular injection

CORTRIL Acetate Ophthalmic Suspension
with TERRAMYCIN** hydrochloride

Pfizer Syntex Products

*BRAND OF OXYTETRACYCLINE

Sole Distributors: PETERSEN LTD., P.O. Box 38, Cape Town. P.O. Box 5785, Johannesburg. 113 Umbilo Road, Durban, S.A.

Pfizer

**PFIZER LABORATORIES
SOUTH AFRICA (PTY) LTD.**

P.O. Box 7324, Johannesburg





PRODUCES sustained bronchial and coronary dilatation.

REDUCES frequency and severity of attacks.

INDUCES subjective and objective improvement.

★ Benecardin is available for oral or intramuscular administration. Literature on request.

Further information is obtainable from —

BRITISH CHEMICALS & BIOLOGICALS (S.A.) (PTY.) LTD.

259 Commissioner Street, Johannesburg. P.O. Box 5788. Telephone 23-1915.